While many people think we've been close to solving our health care problems through a national system, we have not been. We've debated the issue since before World War I (1907) with no results. In fact, Congress has never allowed a national health care bill out of committee.

Health Care for Montanans:
Committee Report and Recommendations
of Working Committees

Submitted to Governor Stan Stephens by:
Julia Robinson, Chairperson
and the Governor's Health Care Committees

Report Prepared by: Bob Frazier, Project Consultant

With federalism has come new responsibilities for the states. It has become quite apparent that if people in Montana want positive changes in health care, we will have to make them as a state.

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GOVERNOR'S RESPONSE TO THE COMMITTEE

Copies of the Governor's response to the committee recommendations and proposals to the legislature are available through the Governor's Office or the Department of Social and Rehabilitation Services.

Health Care for Montanans Committee Report and Recommendations

Overview

Economic Development and education often attract the spotlight for many states priority lists as the most important issues today. However, if polled, citizens often list health care as an equal concern that needs to be addressed. More importantly it is of note,that health care for Montanans is of crucial concern to those who are either trying to develop the state economically or persons who advocate for better education. Most communities who are successful in attracting or expanding businesses or qualified educators cannot do so without adequate health care services. Likewise primary, secondary, or higher education can ill afford to ignore health care for the students they serve. Whether we like it or not, health care has entered into almost every decision we make. Whether it be our mother who cannot live at home anymore or a child who has cancer; or a daughter that is expecting a baby or those family members that have no health care insurance; or that the only doctor we ever knew has retired from a rural community and left us without a physician; or we have a disability and can't access care or insurance coverage; we all face the problems of health care.

In the summer of 1990, in order to address these concerns, Governor Stephens asked Julia Robinson, Director of SRS, and the staff at SRS, to review innovative health care proposals throughout the country with the goal of identifying potential solutions for Montana. These proposals were assembled into a document "Health Care for Montanans." In the fall of 1990, the Governor appointed five working committees to review these proposals and determine:

1. the feasibility of implementing these proposals in Montana and,
2. if they were feasible, to make specific recommendations on how the proposals could be implemented.

In addition to the five newly created committees, the ongoing work of an existing committee, The Governor's Health Care Services Availability Advisory Council, was folded into the total proposal in order to insure a single final committee product for consideration by the Governor and 1991 legislature.

The Governor appointed Julia Robinson as Chair of the overall project in order to insure a continuation of the work begun in the summer and to insure coordination of work in the various committees. The Department of Social and Rehabilitation Services contracted with Mr. Bob Frazier to assist with the committee work. The Governor asked for the committees to finish their work by early December so that he could consider their recommendations and prepare a final report for the 1991 Legislation. In December of

1990, Chairperson Julia Robinson reviewed all committee recommendations with Governor Stephens. From all of the recommendations, the Governor selected those recommendations which he would personally support. The Governor's proposal is contained in the 16 page document "Health Care for Montanans." This document represents the initial recommendations of the committees to the Governor.

* 141,000 Montanans have no insurance coverage
* The number of Montanans over the age of 85 is the fastest growing population
* 49,000 children under the age of 18 have no insurance coverage
* The number of persons seeing a doctor in one month has fallen to a fifteen year low
* Cost shifting accounts for approximately one third of the increase in insurance premiums, which are rising as much as fifty percent a year
* The cost of medical care is increasing two to three times faster than the rate of inflation
* Only half the employers with 100 employees or less offer health insurance
* Montana's Medicaid program averaged 19,709 cases at a cost per case of $299 in 1981, an expenditure of $70,912,000. In 1990 Medicaid served 27,736 persons, with an average cost of $509 and expended $169,476,000.
* Employers who provide insurance spend an average of $2,700 per year to cover health care benefits
* The number of employers providing full payment for health insurance declined from a 1984 total of 37% to a 1990 total of 24%
* Montana covers 100,000 persons through self insurance plans that are not regulated by the state or federal government
* Some insurers "low ball" first year premiums to employers but have been known to increase them up to 200% by the second or third year
* The number of persons served by the Montana Medicaid program increased 40% from 1981 to 1990. The total expenditures for the program increased during that period 139%
* The fastest growing sector of the state general fund is health care. The $125 million allocated to health care represents 10-15% of the general fund
* An employee may not be able to move from one job to another if they have a health care concern. Some employees are held hostage to their current job just to keep their insurance
* Twenty two counties in Montana have no obstetrical or general practice care to deliver babies

* There are presently 88 openings for pharmacists in Montana
* A single employee with a serious disease or disability can earn a rejection slip for the entire company from an insurer
* Employees may be encouraged to find another job if they have made too many health care claims
* There are 48 positions open for doctors in the state of Montana
* While HMO's need to be encouraged because of the aspect of shared responsibility, many are in fiscal trouble
* Montana's rural hospitals are in danger of losing both Medicaid and Medicare reimbursements for their services
* The regulation of catastrophic or long term care policies requires more attention than the present mail order or television approach
* Medicaid makes up 62% of the dollars received by nursing homes
* High risk pools for insurance have drawn few members in Montana or in the United States
* The American Health Care System is the costliest in the world. The US expends 171% more than health care in Great Britain, 124 % more than Japan, 88% more than West Germany and 38% more than Canada
* Health care now consumes 11 1/2% of the gross national product
* Only the US and South Africa fail to provide access to health care for all citizens
* Medicaid pays for 26% of all babies born in Montana
* One hundred and twenty nine high risk births cost the State of Montana 4.2 million dollars last month. This represents half the budget allocation for this area
* Nursing is among the three fastest growing professions in the state
* Over the last five years the cost of health care has risen 42% faster than the cost of food, housing or transportation
* As a country, we rank 12th in life expectancy, 21st in deaths of children under 5, 22nd in infant mortality and 24th in low birth weight babies
* If an HMO closes it doors, those persons who received medical care through the HMO may also be left uninsured
* There are presently 70 openings for physical therapists in Montana
* Montana ranks 41st among the states in its provision of access to health care
* While the vast majority of Montanans have health insurance, thousands teeter on the edge because of increasing costs of health care and insurance premiums
* Very few insurance companies will guarantee to renew your health care coverage. Most policies are "conditionally

renewable" which means if you are refused coverage the company agrees to refuse coverage on all similar policies in Montana

* Companies write between one-fourth and one-half of all policies with exclusion riders
* Most high risk insurance pools operate at a loss despite their high premiums
* Research has shown that the uninsured systematically use less medical care than the insured population, and that they are less likely to seek care when sick
* Two out of five persons aged 65 and older risk needing nursing home care
* One in five of those 85 or older are in a nursing home
* In-patient admissions to hospitals have declined 16% since 1984
* Nearly half of the state's hospitals operated at a loss in 1989
* The difference between the amount hospitals charged Medicare and Medicaid and the amount they were actually paid has increased from 18 to 67 million since 1985

As you can see this list is long and the task of solving the problems is ominous. However, each committee reviewed the initial proposals in light of these concerns and in some cases broadened their deliberations beyond the original change of the Governor. Their recommendations and corresponding background information follows in this report.

Definitions

These definitions are provided for the reader of the Health Care for Montanans Report.

DDD -	Disability Determination Division
DRG -	Diagnosis Related Group
EPSDT-	Early Periodic Screening Diagnosis and Treatment (renamed to Kids Count)
ERISA-	Employment Retirement Income Security Act
HMO -	Health Maintenance Organization
Kids Count-	A program designed to promote prevention and access to health care for children
MIAMI-	Montana's Initiative for the Abatement of Mortality in Infants
WAMI -	Washington Alaska Montana Idaho Medical Training Program
WICHE-	Western Interstate Commission on Higher Education

Health Care for Montanans Working Committee Report and Recommendations

Introduction

In the fall of 1990 Governor Stan Stephens appointed working committees to examine areas of health care. Those areas were: health care services availability, the expansion of private health insurance, insurance coverage for children, long term care strategies and policy and reimbursement for services. Committees met several times to consider proposals from the Governor and his staff and to develop new ideas as proposed by committee members. After a number of meetings and many hours of work each committee winnowed down a list of recommendations to present to Governor Stephens. The committees presented their proposals in early December to the Governor, who then assembled what he felt to be the most comprehensive health care plan from the choices available. The Governor's plan addresses what he feels are the most pressing issues in health care. In addition, it recognizes that his plan does not solve every health care dilemma facing Montanans. Consequently, the Governor has taken those recommendations not used in his plan and formulated them into issues that need study and action in the next biennium.

As you are reading this Report of the Working Committee, you will notice that it contains some unique notions. The plan uses a mix of proposals delivered through public services, private enterprise and the public and private sectors in concert. Some of the proposals have drawn upon expertise and knowledge from other states. Most have been developed by health care professionals and knowledgeable committee members whose ideas can help move Montana's health care service delivery system forward. New federalism has given the states more control over their destinies than ever before. No longer can Montana afford to wait for the federal government to act upon health care issues, we must move ahead and provide the health care system that Montanans deserve.

The Committees: Their goals and Recommendations

As previously mentioned, Governor Stephens appointed health care committees in the fall of 1990 to address areas of need. This section delivers the committee membership, the committee's goals and its recommendations.

Health Care Services Availability Advisory Council

The Members:

Chairman: Dr. Van Kirke Nelson, Kalispell
Dr. Jimmie L. Ashcraft, Sidney
Dr. Gordon K. Phillips, Great Falls

Dr. Jim Hoyne, Clancy
Chadwick Smith, Legal Profession
Larry E. Riley, Legal Profession
Leonard A. Kaufman, The Doctor's Company
Charles Butler, Jr., Blue Cross Blue Shield of Montana
Senator Loren Jenkins, Big Sandy
Paul F. Boylan, Bozeman
Rep. John A. Mercer, Polson
Rep. Paula Darko, Libby
Peggy Guthrie, Health Care Professional, Choteau
John Bartos, Administrator, Marcus Daly Memorial Hospital
Laura Grinde, Health Care Professional, Lewistown
Julia Robinson, Director, Department of SRS
Nancy Ellery, Administrator, Medicaid Division, Dept. of SRS
Keith Wolcott, Department of Institutions
Dale Taliafarro, Administrator, Health Services Division, Dept. of Health and Environmental Sciences

The Goal: The Council was asked to examine and address access and availability of health care in Montana. The council paid particular attention to rural Montana, i.e. hospitals with 50 beds or less or areas without hospital or physician care. Four areas provided the focus for the group:

- Lack of access to emergency care
- Lack of obstetrical or pediatric care
- Lack of access to long term care
- Loss of revenue base to a community when little or no health care exists.

THE RECOMMENDATIONS:

RECOMMENDATION #1

Increase Medicaid compensation for obstetrical and pediatric services. The council endorses the OBRA 89 mandate to states and concurs with SRS and DHES in "Kids Count" with enactment of legislation to follow those recommendations.

RECOMMENDATION #2

Supports the continuation of the "MIAMI" project for the next biennium.

RECOMMENDATION #3

Supports provision of adequate amounts of vaccines to county health departments for necessary immunizations with total costs to be borne by the State of Montana.

RECOMMENDATION #4

To require WAMI and WICHE medical students to pay back eight percent of the yearly support fee. Said funds to be held in a special trust account in the state treasury, the funds to be administered by the university system, the funds, with interest, to be utilized for an "educational relief fund" to those WAMI-WICHE students who return to Montana to practice in rural areas defined as communities in which the hospital is 50 beds or less or where no hospital is present.

RECOMMENDATION #5

A Montana state tax subsidy of $5,000 a year, not to exceed three years for new physicians in rural areas, defined as community in which the hospital is 50 beds or less or where no hospital is present.

RECOMMENDATION #6

That the Montana University system provide adequate educational opportunity to meet the needs of Montana's health care industry.

RECOMMENDATION #7

The establishment of a special trust fund within the Montana Department of Health and Environmental Sciences, administered by a governor appointed board, consisting of a representative of the Montana Hospital Association, the Montana Medical Association, a representative of SRS, a rural physician, two rural consumers and a rural hospital administrator. That a fee, $25.00, be assessed and paid with the filing of each birth certificate with the bureau of vital statistics, Department of Health and Environmental Sciences, by the attendant listed on the birth certificate. The effective date of passage will be the same as date of increased payment for medicaid obstetrical and pediatric services. The bill would sunset in five years. Based on twelve thousand deliveries yearly, the average annual income would be $300,000, or $1,500,000 for five years. The funds to be expended, $100,000 in the first year for updating data gathering capability of the bureau of vital statistics, DHES, in reference to Montana health care, sharing that ability with SRS, the Montana Medical Association and other organizations requiring data on health care. Each subsequent year, for four years, $50,000 per year.

The balance of the funds would be for a direct subsidy of liability insurance (the obstetrical component) for new physicians in rural areas for a maximum of three years and to assist communities in physician recruitment through subsidy of matching funds with criteria to be established by the board for that match. That the statute sunset in five years, the board to continue administration of grants from the interest on the corpus of the trust. Further,

that a one half hour documentary video tape on the benefits of rural practice be produced and disseminated advocating the advantages of a rural Montana practice and the potential subsidies offered by the State of Montana.

RECOMMENDATION #8

Strong concurrence with the AARP, the American Association of Retired Persons, opposing mandatory assignment, which if enacted by the Montana Legislature, would further erode physician availability in rural Montana and access to an aging population.

RECOMMENDATION #9

Strengthening tort reform through 1. modification of "Good Samaritan Law" to protect physicians, hospital and health care providers when rendering emergency care. 2. limitation of damage provisions, a fact-based discretionary "ceiling" on non-economic damages. 3. mandatory periodic payment - see addendum 3.

RECOMMENDATION #10

The council supports the strengthening of the medical practice act by the Board of Medical Examiners and further, supports the addition of a "paralegal" to the board of medical examiners, the cost through increase in medical licensure fee.

Expansion of Private Health Insurance Committee

The Members:

Chairman Rep. Fred Thomas, Stevensville
Alan Cain, Blue Cross Blue Shield of Montana
Chuck Butler, Blue Cross Blue Shield of Montana
Denis Adams, Director, Department of Revenue
David Barnhill, Deputy Commissioner of Insurance
Mike Craig, Dept. of Health and Environmental Sciences
Terry Frisch, Third Party Liability, Department of SRS
Chuck Brooke, Director, Department of Commerce
Bob Anderson, Department of Institutions
Brian Zins, Montana Medical Association
Dick Brown, Montana Hospital Association
Rep. Jerry Driscoll, AFL-CIO, Billings
Rep. Jan Brown, Helena
Rep. John Cobb, Augusta
Tom Hopgood, Attorney, Helena
Mona Jamison, Attorney, Helena
Julia Robinson, Director, Department of SRS

The Goal: It is presently estimated that 141,000 Montanans do not have health insurance. The uninsured population increasingly is forced to forgo all forms of health care until their situations reach chronic proportions. In order to address this lack of access to health care through insurance, the committee was asked to design a basic health plan to meet this population's needs. The target group includes small businesses, persons who are self employed, injured or disabled workers, children of absent parents and families of workers who receive worker's compensation.

THE RECOMMENDATIONS:

RECOMMENDATION #1

Small Business Incentive Tax Credit

In order for a company to receive the small business incentive tax credit, the following measures must be met:

* Existing Montana businesses who do not offer health insurance.
* The credit can apply up to ten employees.
* The business must pay at least 50% of their employees health insurance costs.
* Credits are graduated up to $25 per month. Example: 50% payment by the company equals a credit of $12.50, 75% equals $18.75, and 100% equals $25.00.
* The credit would sunset three years after enacted.

RECOMMENDATION #2

Maternity and Newborn Services

Payment will be made to licensed or certified providers for maternity care and shall be made on the same basis as any other condition. Licensed birthing rooms are covered. The newborn child of a covered employee or spouse shall be covered at instant-of-birth for thirty-one days with routine hospital nursery and pediatric care. If the newborn is the child of someone other than a covered employee or spouse (ie. grandchild), the child will not have instant-of-birth coverage.

RECOMMENDATION #3

Well Child Care

Well child checkups and immunization are provided for children under the age of 2.

RECOMMENDATION #4

Psychiatric and Substance Abuse

A lifetime benefit of $1000 is provided for either licensed inpatient or outpatient care by any Montana licensed provider or licensed facility.

RECOMMENDATION #5

Hospital and Other Medical Services

The plan will include hospital and other medical services as determined by the carrier excluding the psychiatric and substance abuse as covered by recommendation number 4.

RECOMMENDATION #6

The Base Plan

The committee adopts the five previous recommendations as its Basic Health Care for Montanans Plan.

RECOMMENDATION #7

Business Qualifications for the Plan

* All business with 20 or fewer employees can qualify.
* Employees are defined as anyone working 20 or more hours per week.

* A company must have been without health insurance for twelve consecutive months to qualify. (Note: Individual coverage for injured workers has no waiting period.)

Insurance Coverage for Children Committee

The Members:

Chairman: Alan Cain, Blue Cross Blue Shield of Montana
Chuck Butler, Blue Cross Blue Shield of Montana
Elizabeth Roeth, Exec. Director, Healthy Mothers Healthy Babies
Jim Aherns, President, Montana Hospital Association
Dan Anderson, Department of Institutions
Judy Wright, Dept. of Health and Environmental Sciences
Dee Capp Harrington, Medicaid Division, Department of SRS
Dr. Jeff Strickler, Helena
Brian Zins, Montana Medical Association
Julia Robinson, Director, Department of SRS

The Goal: Children are perhaps the most underinsured population. As one can well imagine, children often have little choice when it comes to insurance matters. While Medicaid covers many children along with private insurance carriers, about 49,000 of Montana's children under the age of 18 have no coverage. Therefore, it was the charge of the committee to work with Blue Cross/Blue Shield for the successful implementations in Montana of the Caring for Children Program. This program is a Blue Cross/Blue Shield program currently administered in 12 other states. The committee also felt it was important to address the issues of immunizations and prevention services for children.

THE RECOMMENDATIONS:

RECOMMENDATION #1

The committee endorses the Kids Count program as proposed by the Governor and the cooperating state departments.

RECOMMENDATION #2

The committee endorses the Caring Program for children and recommends that it be enacted by Blue Cross/Blue Shield in concert with medical providers including physicians and hospitals. The state of Montana should cooperate in identifying children to be served by the program.

The Caring Program for Children -

Purpose:

- To provide immunizations and early diagnoses that may help prevent children from becoming seriously ill
- To maintain the health of children

- To provide emergency health care services

Benefits provided for children:

- Doctors well/sick office visits
- Emergency accident and medical treatment
- Out-patient surgical care
- Out-patient diagnostic tests
- Immunizations
- Prescriptions

Funding:

- Provided by contributions to the Caring Foundation of Montana, Inc., a non-profit 501C3 subsidiary of Blue Cross and Blue Shield of Montana through individual, business, civic and community support.

Commitment:

- Blue Cross and Blue Shield of Montana, as their contribution, will donate ALL administrative and program costs for the Caring Program. This means that ALL donated funds -- 100% -- will be used to provide health care services for these children. This effort is in keeping with the Blue Cross and Blue Shield of Montana concept to make affordable health care available for all children of eligible families.

RECOMMENDATION #3

Proposed Recommendation on Immunizations

There is growing concern in the state that Montana's immunization program is not adequately funded to meet current needs. It is becoming increasingly apparent that additional resources need to be spent to fund the costs of new vaccines or to allow private physicians to offer state financed vaccines through their offices. Furthermore, the state should address the problems of vaccine distribution with both public and private sources. A review of this issue indicated that the Department of Health met all requests last fiscal year. This did not, however, include new vaccines or physician usage. The committee strongly believes that vaccinating children is a cost-effective method (return is $10 for every $1 expended) of reducing health risks and subsequent health care

costs. In order to encourage the broadest vaccination of Montana's children possible, this committee recommends that the State Board of Immunization develop a comprehensive plan for providing immunizations and that the Department of Health present the plan in full to ensure that the Legislature and Governor will have an accurate cost measure for future budgeting based on actual usage.

KIDS COUNT SECTION

RECOMMENDATION #4

Increase reimbursement for delivery services to 90% for OB GYN's and physicians delivering babies, and 80% for pediatricians of the average customary charge for the service. This would increase the global fee for a normal delivery to $1,235. This level of increase should be sufficient to meet the federal requirement that services must be available to Medicaid clients to at least the extent they are available to the general population.

RECOMMENDATION #5

Implement a targeted case management system for women who are identified by assessment to be at high risk of not delivering a full-term baby. The Medicaid program could reimburse eligible contract providers for case management services. Potential providers of case management services would be DHES low birth weight clinics; migrant health clinics; urban Indian Health (IHS) clinics and IHS clinics for special needs population.

RECOMMENDATION #6

Develop strategies for continued funding of current low birth weight (LBS) projects and expand to additional sites as part of the MIAMI Project expansion.

RECOMMENDATION #7

Continue education efforts to pregnant women on the importance of the "Baby Your Baby" project and encourage agencies to help fund a "corporate sponsorship" of this project.

RECOMMENDATION #8

Adopt the American Academy of Pediatrics Screening Schedule for the EPSDT program increasing the number of screens from 12 to 20 during the first 21 years of life.

RECOMMENDATION #9

Increase public awareness and child-find activities throughout the state.

The Part H infant and toddler program, requires participating states to inform the public about the statewide early intervention program and the child-find system, including how to make referrals and how to gain access to evaluation and services. The child-find system should set up an effective method for hospitals, physicians, parents, day care programs and other providers to refer children to the early intervention system for evaluation and assessment.

To ensure a true interagency approach to child-find activities, the system must provide for coordination among the state's special education child-find program, the Maternal and Child Health program, Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, state developmental disabilities programs and Head Start.

RECOMMENDATION #10

Demonstrate increased interagency cooperation through the development of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.

Special emphasis should be placed on the development of coordinated strategies to locate children with disabilities or at risk of becoming disabled as soon after birth as possible.

Information gathered through the Department of Health and Environmental Sciences' Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Project and the "Baby Your Baby" public education project should be utilized as a basis for development of a risk registry. Other agencies would need to cooperate with this effort and enter into agreements that would allow for sharing information while at the same time protecting the confidentiality rights of Montana's citizens. Specific tracking and follow along procedures could be developed utilizing the public health system already in place in the counties throughout the state.

RECOMMENDATION #11

Enter into formal interagency agreements with other state-level agencies involved in the state's early intervention program.

Each agreement should define the financial responsibility of the agency for paying for early intervention services, include procedures for resolving intra- and interagency disputes and any additional components necessary to ensure effective cooperation and coordination among all agencies involved in the state's early intervention program.

RECOMMENDATION #12

Make the policy commitment required by PL 99-457 to implement a statewide, comprehensive, coordinated, interagency, multi-disciplinary system of early intervention services for infants and toddlers with handicaps and their families.

In order to continue to receive federal Part H early intervention grant funds and maintain services to approximately 100 Montana families using Part H dollars, the State of Montana must make a policy commitment to fully implement Part H and provide the full menu of services called for by the federal legislation. Such a commitment will require a further appropriation of state funds in FY 92-93 as well as improved utilization of existing federal, state and local resources.

A conservative definition of "developmental delay" such as the one tentatively adopted by DDD to determine eligibility for Part H services would make approximately 1.5 percent of the Montana children under the age of three years of age eligible to be served. Currently 210 children under 36 months of age receive some, but not all of the required services. The proposal to fully implement Part H will provide the level of early intervention and family support services required by Part H to children currently in the program as well as those eligible children yet to be located, evaluated and served. The projected cost to the state general fund for the full implementation of the Part H infant and toddler program is $1,180,000 in FY 92 and $1,380,000 in FY 93.

RECOMMENDATION #13

Establish a State Center for Health Statistics (SCHS) housed in DHES. The SCHS would be responsible for collection and storage of data, compiling required reports and disseminating identified data profiles on a periodic basis. The U.S. Public Health Service, Centers for Disease Control, would provide the standards and federal coordination and reporting requirements.

Long Term Care Strategies Committee

The Members:

Chairman: Hank Hudson, Aging Coordinator, Governor's Office on Aging
Susan Good, Great Falls
Mike Hanshew, Medicaid Division, Department of SRS
Cheryl Fowler, Insurance Department
Denis Adams, Director, Department of Revenue
Charles Aagenes, Dept. of Health and Environmental Sciences
Rose Hughes, Executive Director, Montana Health Care Association
Jean Johnson, Executive Dir., Montana Assoc. of Homes for the Aging
Bob Olson, Vice President, Montana Hospital Association
Vi Thompson, Chairperson, Governor's Council on Aging
Laurie Brengle, Pres., Area Agency on Aging Director's Association
Joan Taylor, Case Management Association
Jane Anderson, Area Agency Director, Anaconda
Jack Gallagher, Deaconess Medical Center, Billings
Riley Johnson, Helena

The Goal: Currently one in six or 120,000 Montanan's are over the age of 65. Those persons over the age of 85 are the fastest growing population in the state. As this trend continues, Montana will need to address the issue of long term care and the strategies that will be designed. The Long Term Care Committee was asked to examine avenues including long term care insurance, identifying the balance between institutional and community based care, the potential expansion of home and community based options and to examine what role utilization fees would have in the provision of funding for long term care.

THE RECOMMENDATIONS:

RECOMMENDATION #1

To expand the present Elderly Care Credits Act to include the following:

* Decrease the age limit of the elderly person cared for from 70 to 65.
* Allow the credit for expenditures related to care of a person who is considered disabled under the Social Security Administration classification.
* Allow as creditable expenses those paid by the family member(s) to all health care facilities licensed by the Department of Health.

* Increase the income threshold for a married couple cared for from $15,000 to $30,000. This corrects an oversight in the original legislation.

RECOMMENDATION #2

To provide Montana citizens with a tax deduction for the purchase of Long Term Care insurance. The deduction would be 100% for premiums paid for by individuals. Only Long Term Care Insurance which meets standards set by the INsurance Commissioner's Office would be eligible for the deduction.

RECOMMENDATION #3

The State employees health care plan should explore a long term rider as part of a cafeteria plan.

RECOMMENDATION #4

The Department of Social and Rehabilitation Services should be granted the authority to pursue waivers from the Federal government, that reduce the costs of Long Term Care, both to individuals and State Medicaid programs, by encouraging the use of Long Term Care Insurance.

RECOMMENDATION #5

The Department should have the ability to determine the best strategy for administering the Medicaid Wavier Program, including the ability to choose between the expansion of current waiver caseloads or the development of waiver services in new locations across the state.

In addition, an expansion of the Medicaid Waiver Program should be pursued.

RECOMMENDATION #6

To authorize the Department of Social and Rehabilitation Services to establish a pilot program for personal care homes in four sites. The sites would range in size from large facilities greater than 35 beds, to medium facilities of 16 to 35 beds, and to small facilities of 15 beds or less and would include freestanding and attached facilities.

RECOMMENDATION #7

To support adequate funding for all long term health care services and continued commitment to the leveraging of Federal funds through fees or other funding mechanisms.

RECOMMENDATION #8

To direct the Governor's Office on Aging and the Department of Social and Rehabilitation Services to apply for Federal or private funds, to begin a pilot project that would provide a single point of entry for long term care services. It would seek to accomplish the following:

* A single point of access for all publicly funded long term care programs.
* An assessment of each applicant, including an individualized care plan.
* A smooth transition from private funds to eligibility for public programs.
* Assurance that all funding sources are maximized for each client.
* Educational opportunities for clients and families concerning options for long term care.

Hospital Policy and Reimbursement Committee

The Members:

Chairman: David Richhart, VP, St. Peter's Community Hospital, Helena
Terry Krantz, Medicaid Division, Department of SRS
Kip Smith, Medicaid Division, Department of SRS
Ray Worthington, Assist. Admin., Barrett Memorial Hospital, Dillon
Lanna Blackwell, Bus. Manager, Barrett Memorial Hospital, Dillon
Joel Lankford, VP, Columbus Hospital, Great Falls
Loren Jacobson, VP, St. Patrick's Hospital, Missoula
Sherry Abel, Controller, Kalispell Regional Hospital
Bob Olsen, VP, Montana Hospital Association
Debbie Kvale, Mgr.,Financial Services, St. Vincent's Hospital, Billings
John Bartos, Admin., Marcus Daly Memorial Hospital, Hamilton
Chuck Schindele, Controller, MT Deaconess Medical Ctr, Great Falls
Gary Ophus, Accountant, MT Deaconess Medical Ctr, Great Falls
Mary Schwartz, Provider Relations, Consultec
Mike Wagner, Senior Director, Blue Cross Blue Shield
Jim Shelton, Dir. of Patient Accounts, Columbus Hospital, Great Falls
Cheryl Rust, Office Manager, Broadwater Health Center, Townsend

The Goal: The Hospital Committee was asked to address the cost implications of providing hospital services to rural areas and insuring that Montanans would have access to care. In addition the committee was asked to examine Montana's health care policies and recommend changes that need to be made.

THE RECOMMENDATIONS:

RECOMMENDATION #1

The State of Montana does not need to develop a program for charity care or define the hospital's obligation to provide charity care.

RECOMMENDATION #2

State government should fully fund and structure programs that the state is responsible for, ie. Medicaid, State Medical and Workers' Compensation. The eligibility criteria should be maintained at current levels. The state's programs should not shift the population of insured persons under Medicaid to increase the uninsured population.

RECOMMENDATION #3

The State of Montana should develop policies for revenue provision that fully fund all state obligations. Revenues for health care needs should be borne by the general population and not through selected fees.

RECOMMENDATION #4

DRG trauma and outlier policy, mental health, rehabilitation, neonatal and cardiovascular care should be rebased for the upcoming biennium. Appropriate funding should be provided by the state to meet the needs of rebasing.

RECOMMENDATION #5

The State of Montana should fully fund health care training programs through the university system to meet employment needs of health care providers.

RECOMMENDATION #6

The State of Montana should create an Office of Rural Health to serve as the focal point for rural health care issues.

RECOMMENDATION #7

The State of Montana should develop a health care policy to address access and delivery of services. The policy should be that health care decisions are based on health care planning not on a budgetary process. The Governor should appoint a committee to develop such a plan and provide their findings to the 1993 Legislature. A health care conference should be convened after the 1991 legislative session to further address health care concerns and appoint such a council.

RECOMMENDATION #8

The state of Montana should establish a pool of funds to provide loan forgiveness to persons who practice in rural settings within health care professions.

I. UNINSURED MONTANANS - PART 1

As previously mentioned, Montana has 141,000 people who don't have health insurance. Their lack of coverage and access to medical care causes not only great difficulties for them but also for the insured population and the State of Montana. As most of us know someone will eventually pick up the tab, whether it be through cost shifting, increased premiums or sending the bill to the State. It is therefore important to examine some of the potential solutions to the crisis that is growing on a daily basis within the health care area. They are as follows:

A. ENCOURAGE PEOPLE TO USE FEWER MEDICAL SERVICES BY WRITING HIGHER DEDUCTIBLES INTO POLICIES - This proposal has two distinct sides. While higher deductibles may discourage unnecessary services usage, there is a danger that people will postpone necessary treatment. This postponement could make more costly procedures necessary or for some people could be too late.

B. INSTITUTE MANAGED CARE - Managed care includes formal programs that monitor the quality of treatment and determine whether the care is appropriate for the patient's condition. Managed care institutes some of the control doctors have objected to in national health insurance plans. It also has created the health care cost management business, one of the fastest growing segments of the health care industry. Managed care may eventually be an answer to health care costs.

C. ESTABLISH RISK POOLS - While many states have set up risk pools for persons who can get no health insurance coverage due to medical conditions, the pools suffer from two striking problems. The pools are often extremely expensive and many have long waiting lists that require up to a year to receive coverage. Montana is presently one of the states offering such a pool.

D. EXPANSION OF MEDICAID COVERAGE - Nationally, Medicaid covers 70% of everyone under poverty guidelines. Today, Montana now covers 51%. One proposal is for everyone up to 200% of poverty be able to "buy" Medicaid coverage. The "buy" portion of this proposal would comply a sliding scale of purchase with the state and/or federal government being a financial partner in the policy's purchase.

E. REFORM INSURANCE COMPANY PRACTICES ON WAITING PERIODS AND PRE-EXISTING CONDITIONS - This proposal would eliminate exclusion riders for certain health conditions.

F. REQUIRE ALL EMPLOYERS TO OFFER COVERAGE - Many state and federal proposals exist that would require employers to carry health insurance on their employees. Most proposals consider employees "full-time" at about 20 hours per week. Many

require between 75 and 80% of the costs be borne by employers. Plans such as those recommended by the Pepper Commission actually impose a form of taxation on employers who don't provide health insurance. Without some tax relief tradeoff these plans will most likely force small businesses to hire more "part-time" workers to get around these proposals.

G. UNIVERSAL HEALTH INSURANCE - This approach has often been suggested although no real progress has been made since the discussion was initiated in the early 1900's. Montana should not hold out hope that national health care coverage will come any time soon.

H. ALTER STATE MANDATED BENEFITS - Health insurers claim and in some cases rightly so that mandated coverage drives the cost of health care much higher than it need be. Insurers question the value of some services provided by health care professionals, however, there has been no information what the cost savings would be if some mandates were lifted. Most analysts agree however that the preventative and maintenance mandates have a positive impact on the health care system and should not be lifted.

I. DESIGN LOW COST POLICIES - This method allows exemptions in health care coverage presently offered by employers. It most likely will come with higher deductibles or copayments and often has aspects of managed care or HMO coverage. While it may not be the final answer, it does provide a starting point for those needing insurance.

Please Note:

Solutions H and I were the combined choice of the committee who dealt with the uninsured population's needs. The plan they developed is outlined in the next section.

Health Care Plan for Montana's Uninsured

The Goal: The mission of the Committee on Expanding Private Health Insurance is to provide a basic health care plan to persons who are uninsured and who fall into the following categories: employers with 20 or fewer employees, families of disabled or injured workers, unemployed workers, individuals with medical support obligations and self employed or employees working within small businesses. To qualify as a business, the eligible business must not have had health insurance in the last twelve months. Persons falling into the categories of injured, disabled and unemployed workers, along with individuals with medical support obligations have no waiting period. Broad flexibility is left to insurers, in terms of coverage, deductions, and copayments to encourage competition and keeping plan costs at minimal levels.

THE RECOMMENDATIONS

RECOMMENDATION #1

Small Business Incentive Tax Credit

In order for a company to receive the small business incentive tax credit, the following measures must be met:

* Existing Montana businesses who do not offer health insurance.
* The credit can apply up to ten employees.
* The business must pay at least 50% of their employees health insurance costs.
* Credits are graduated up to $25 per month. Example: 50% payment by the company equals a credit of $12.50, 75% equals $18.75, and 100% equals $25.00
* The credit would sunset three years after enacted.

RECOMMENDATION #2

Maternity and Newborn Services

Payment will be made to licensed or certified providers for maternity care and shall be made on the same basis as any other condition. Licensed berthing rooms are covered. The newborn child of a covered employee or spouse shall be covered at instant-of-birth for thirty-one days with routine hospital nursery and pediatric care. If the newborn is the child of someone other than a covered employee or spouse (ie. grandchild), the child will not have instant-of-birth coverage.

RECOMMENDATION #3

Well Child Care

Well child checkups and immunizations are provided for children under the age of 2.

RECOMMENDATION #4

Psychiatric and Substance Abuse

A lifetime benefit of $1000 is provided for either licensed inpatient or outpatient care by any Montana licensed provider or licensed facility.

RECOMMENDATION #5

Hospital and Other Medical Services

The plan will include hospital and other medical services as determined by the carrier excluding the psychiatric and substance abuse as covered by recommendation number 4.

RECOMMENDATION #6

The Base Plan

The committee adopts the five previous recommendations as its Basic Health Care for Montanans Plan.

RECOMMENDATION #7

Business Qualifications for the Plan

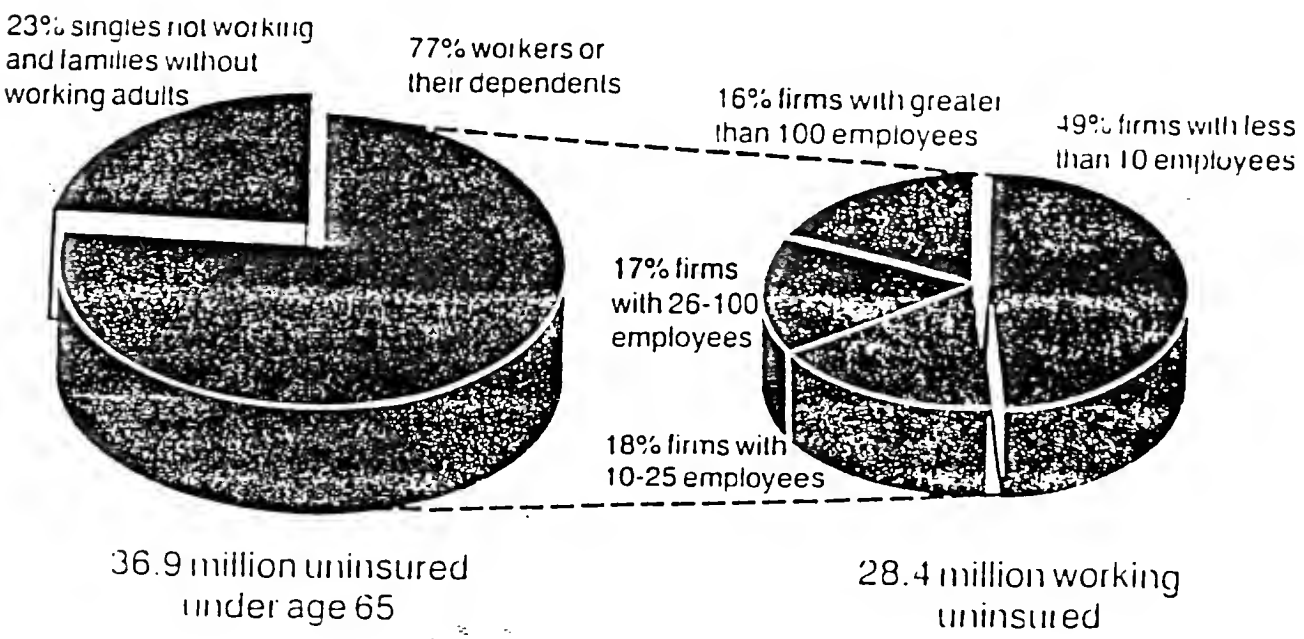
* All business with 20 or fewer employees can qualify.
* Employees are defined as anyone working 20 or more hours per week.
* A company must have been without health insurance for twelve consecutive months to qualify. (Note: Individual coverage for injured workers has no waiting period.)

Appendix I

The following charts and graphs provide further information about the United States uninsured population.

CHART 1

Nearly Half of the Working Uninsured Are Employed in Very Small Firms



Source: Derived from NCHSR analysis of NMES data first quarter 1987

(United States statistics)

TABLE 6
Reasons Reported by Small Employers For Not Offering Health Insurance to Their Employees

Factors In Decision Not to Offer Insurance	Alabama (Birmingham)	San Diego	Denver	Maine (Brunswick)	Wisconsin (4 Counties)
Cost:					
Too Expensive	64.7	69.0	56.1	49.2	77.6
Firm Not Sufficiently Profitable	25.0	41.0	—	31.4	44.8
Workforce Considerations:					
Many Employees Insured Elsewhere	67.3	49.0	46.5	35.6	63.1
Employees can be Hired Without Providing Insurance	42.8	33.0	57.6	19.6	44.9
High Employee Turnover	19.0	22.0	23.2	13.6	19.0
Employees Don't Want It	39.1	25.0	16.0	12.7	43.9
Insurance Market:					
Company Turned Down: Too Small	25.0	22.0	19.2	10.3	•
Cannot Find An Acceptable Plan	22.8	32.0	24.5	14.7	31.5
Lack of Information/ Difficulty Judging Plans	17.9	19.0	16.9	16.0	31.6
Employees Cannot Qualify: Preexisting Conditions	11.3	10.0	8.6	7.9	24.1
Company Turned Down: Type of Business	11.4	7.0	2.9	•	•

*Survey did not ask this question.

TABLE 7
Portion of Premium Paid by Employers for Full-Time Employees and for Dependents

Portion of Premium Paid by Employer	Arizona (Statewide)		San Francisco		Denver		Maine (Brunswick)		New Jersey* (15 Counties)		Wisconsin (4 Counties)	
	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.
All	54.1	23.2	79.0	32.0	73.6	37.9	65.0	38.8	84.0	62.0	64.5	52.8
Some	21.7	10.1	17.0	14.0	21.4	14.6	25.8	41.4	14.0	10.0	31.1	31.1
None	24.3	66.7	2.0	50.0	5.0	47.5	9.2	19.8	2.0	8.0	4.4	16.2

*For dependent coverage in New Jersey, 20 percent reported "not applicable/ineligible" or "don't know."

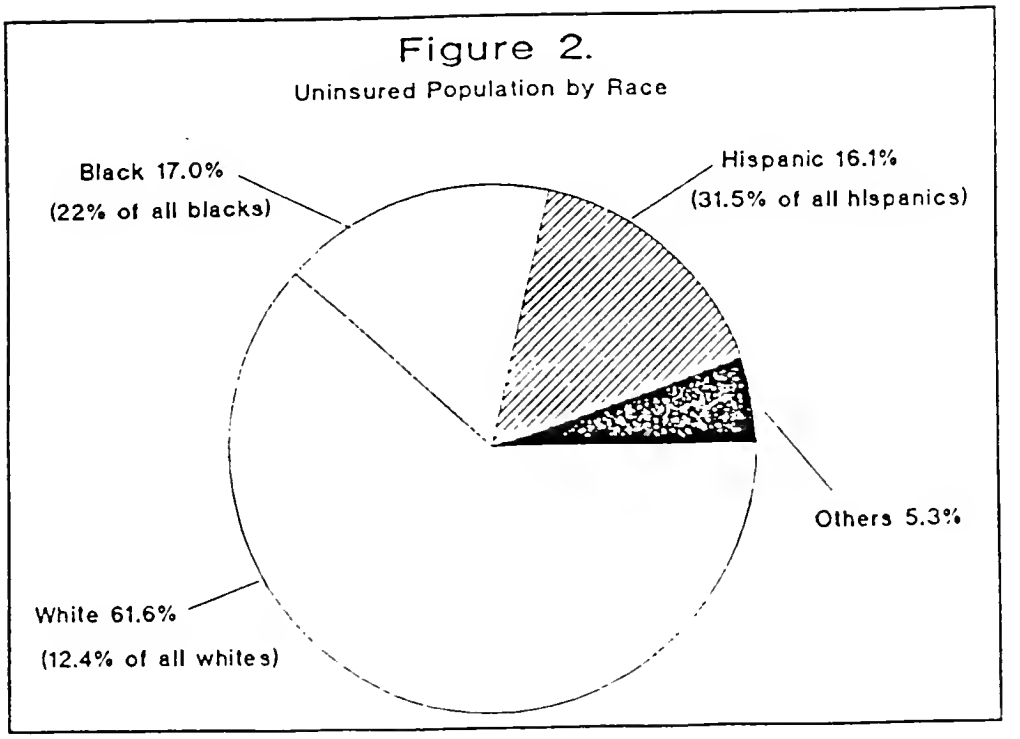


Figure 2.
Uninsured Population by Race
Black 17.0%
(22% of all blacks)
Hispanic 16.1%
(31.5% of all hispanics)
Others 5.3%
White 61.6%
(12.4% of all whites)

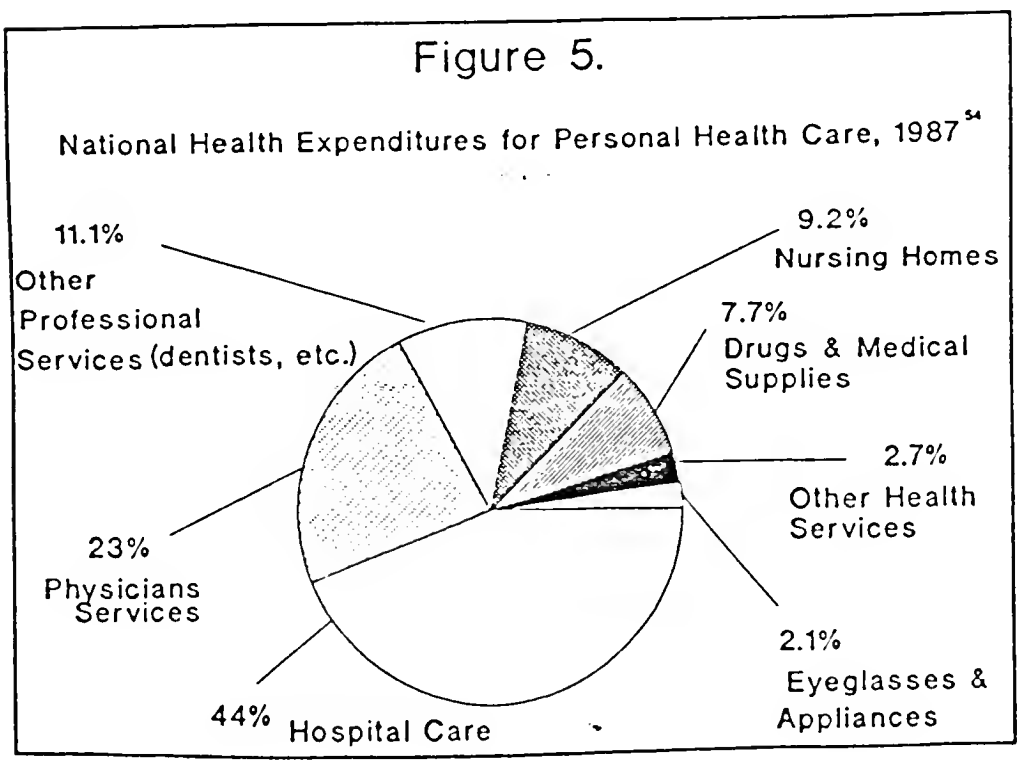
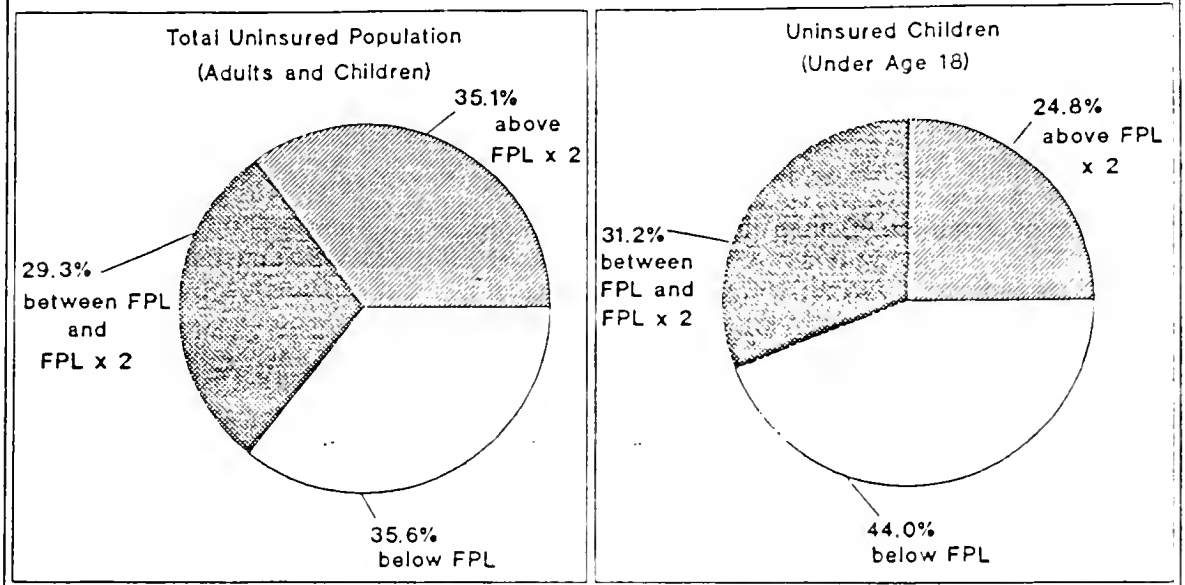


Figure 5.
National Health Expenditures for Personal Health Care, 1987
11.1%
Other
Professional
Services (dentists, etc.)
9.2%
Nursing Homes
7.7%
Drugs & Medical
Supplies
2.7%
Other Health
Services
2.1%
Eyeglasses &
Appliances
23%
Physicians
Services
44%
Hospital Care

Figure 3.

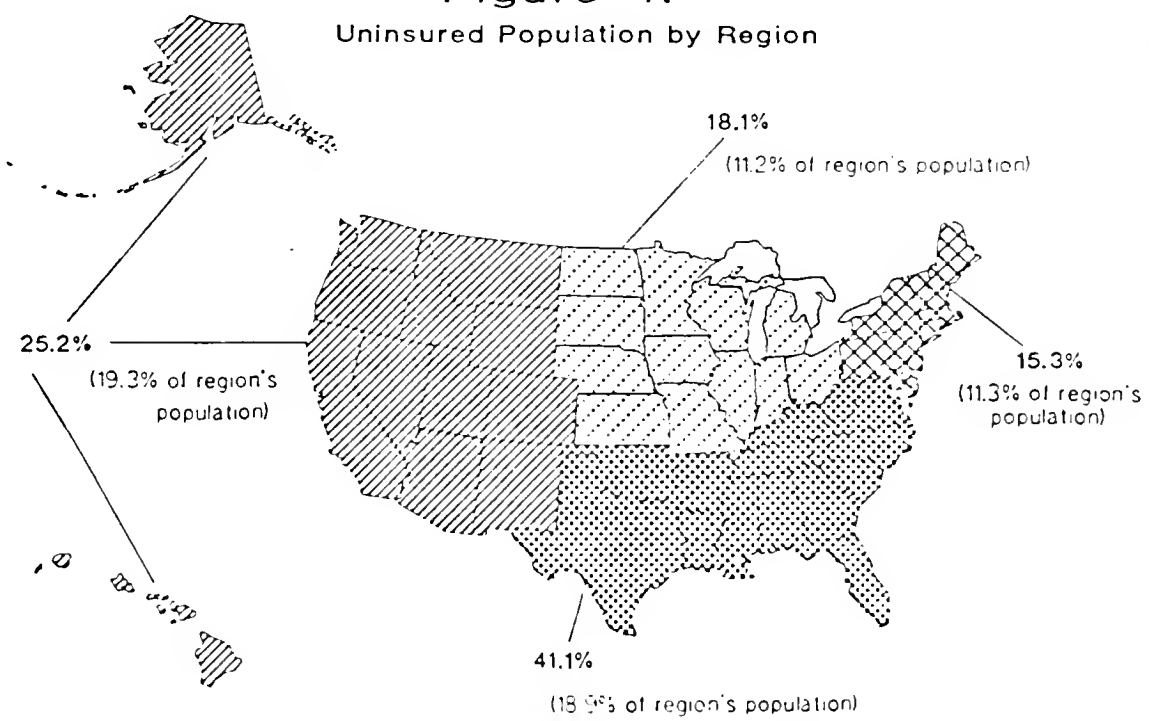
Uninsured Population by Family Income



FPL: Federal Poverty Level (see the glossary)

Figure 4.

Uninsured Population by Region



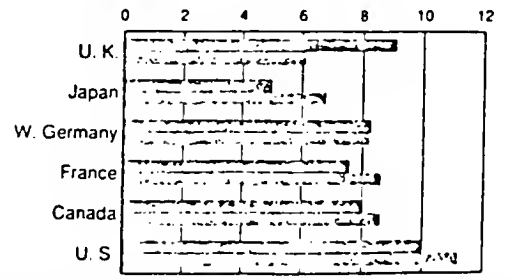
Bold numbers indicate the percentage of the total uninsured population in the country

HIGH COSTS, POOR RESULTS

Though the U.S. spends a higher percentage of its Gross Domestic Product on health care than these five other industrialized nations, its record on infant mortality is the poorest of the group. (Gross Domestic Product is the monetary value, at market prices, of all goods and services created in a country in a given year. Infant mortality is a commonly used measure of the overall health of a nation, reflecting how well medical services are delivered throughout its population.)

☐ Health expenditures as a percentage of Gross Domestic Product

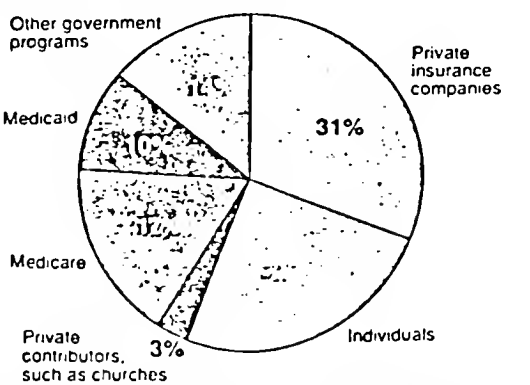
☐ Infant mortality per thousand births



Sources: Health Care Financing Review, 1989, Annual Supplement. UN Children's Fund, State of the World's Children, 1989, Organization for Economic Cooperation and Development, Health Data Bank.

WHO WRITES THE CHECKS?

As costly as the private-insurance system is, it pays only 31 percent of the U.S. health-care bill. At least 25 percent comes directly out of Americans' pockets.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1988

Appendix II

The subsequent two pages reveal insurance projects in other states and the type of coverage they provide and the cost of the plans. In addition, the final two pages of this section the selected benefits covered in the plans and the frequency of selected types of coverage.

Plan Features

INSURANCE PROJECT	SERVICE DELIVERY NETWORK[1]	DEDUCTIBLE	COINSURANCE CAP, OUT-OF-POCKET MAXIMUM	MAXIMUM BENEFIT AMOUNT	PRE-EXISTING CONDITION CLAUSE[2]
Alabama: Basic Care Private Option—A	Network model HMO of public and private hospitals and private physicians	$100 per individual per contract year, $300 per family	$1,080 per person per year—deductible plus coinsurance $3,240 per family	Unlimited (Limited benefit package)	12-6-12
Alabama: Basic Care Public Option—B	Network model HMO of publicly supported hospitals and county primary care clinics	Same as above	Same as above	Same as above	Same as above
Arizona: Health Care Group Option One	Network model HMO in 2 counties, IPA in 1 county	None	$4,000 per person per year participant's coinsurance	$250,000 per person per year	12-12 for inpatient services (pregnancy: normal delivery not covered for 10 months from enrollment)
Arizona: Health Care Group Option Two	Same as above	None	None	$250,000 per person per year	Same as above
Arizona: Health Care Group Option Three	Same as above	None	None	$20,000 per person per year	Same as above
Arizona: Health Care Group Option Four	Same as above	$2,000 per individual per contract year	$2,000 maximum out-of-pocket per person per year	$250,000 per person per year	Same as above
Denver: SCOPE	EPO, co-payments waived for low-income persons using publicly-supported hospitals	Inpatient care—$250 per individual per calendar year, $500 per family. Outpatient prescription drugs—$50 per year	$2,750 per person per year deductible plus coinsurance, $5,500 per family	Unlimited (Exceptions: mental health, substance abuse, hospice care, convalescent care, person over 70)	3-3-6 employee 3-3-12 dependent
Florida: Florida Health Access Standard Option	IPA model HMO, (nonprofit)	None	$1,500 per person per calendar year—total copayments, $3,000 per family	Unlimited	None
Florida: Florida Health Access High Option	Same as above	None	Same as above	Unlimited	None
Maine: MaineCare	IPA model HMO	None	None	Unlimited	Exists 90 days after enrollment, but does not apply to pregnancy
Michigan: Blue Cross Blue Shield Option	Blue Cross/Blue Shield affiliated providers, indemnity plan	$100 per individual per calendar year, $200 per family	$1,100 per person per year deductible plus coinsurance, $1,200 per family	$1,000,000 per person—lifetime benefit, all causes	6-6 for groups 4 or less (pregnancy—at least 270 days from enrollment), no clause for groups 5 or more
Michigan: Blue Care Network Option	Mixed model HMO, staff and network components	None	None	Unlimited (some benefits limited)	None
Tennessee: MedTrust	HMO including clinics and physicians from Tenn. Primary Care Network	None	$500 per person per year or $1250 per family maximum out-of-pocket	Unlimited	6-3-12
Utah: Community Health Plan	Network model HMO including community health centers and private physicians	None	None	$1,000,000 lifetime benefit maximum all causes	Conditions for which medical advice was received 24 mo. before enrollment, or treatment for 12 mo., are covered at 50% for first 12 mo.
Washington: Basic Health Plan	Variety of staff, network and IPA model HMO's	None	None	Unlimited	6-12

[1] Service Delivery Network Abbreviations: HMO — Health Maintenance Organization EPO — Exclusive Provider Organization IPA — Individual Practice Association

[2] Pre-existing condition clause: Numerals refer to time periods in months unless otherwise noted, e.g. 12-6-12 means that if the person received treatment for a condition within 12 months before enrollment, that condition would not be covered until the person has been treatment-free for six continuous months while insured, or has been enrolled for 12 continuous months. A 12-12 plan would eliminate the treatment-free clause.

Monthly Premiums for an Adult Employee Age 35[1]

INSURANCE PRODUCT	SINGLE		FAMILY[2]			REQUIRED EMPLOYER CONTRIBUTION
	MALE	FEMALE	2-PERSON OR COUPLE	3-PERSONS	4 OR MORE PERSONS	
Alabama: Private Option—A	73.96	73.96	186.32	186.32	186.32	50% of single premium
Alabama: Public Option—B	45.07	45.07	110.86	110.86	110.86	50% of single premium
Arizona[3]: Option One	82.02	82.02	160.79	259.89	259.89	None required
Arizona[3]: Option Two	93.73	93.73	183.81	298.12	298.12	None required
Arizona[3]: Option Three	90.14	90.14	176.98	276.87	276.87	None required
Arizona[3]: Option Four	55.43	55.43	108.68	180.12	180.12	None required
Denver[4]: SCOPE	51.94	71.54	148.47	148.47	148.47	25% of single premium
Florida: Standard Option	72.52	72.52	145.82	198.95	198.95	50% of single premium
Florida: High Option	82.42	82.42	162.72	226.11	226.11	50% of single premium
Maine: MaineCare						
Unsubsidized (201% + FPL)	91.71	91.71	183.42	274.23	274.23	50% of unsubsidized rate
Subsidized (101-125% FPL)	64.55	64.55	129.10	174.93	174.93	
Michigan[5]: Blue Cross Blue Shield Option						
Unsubsidized (201% + FPL)	118.06	118.06	271.03	283.93	283.93	33.3% of unsubsidized rate
Subsidized (101-200% FPL)	78.71	78.71	180.69	189.29	189.29	
Michigan[5]: Blue Care Network						
Unsubsidized (201% +FPL)	112.56	112.56	261.00	277.90	277.90	33.3% of unsubsidized rate
Subsidized (101-200% FPL)	75.04	75.04	174.00	185.27	185.27	
Tennessee: MedTrust	48.71	48.71	97.43	131.53	131.53	$30.00 per month
Utah[6]: Community Health Plan	63.57	73.75	137.32	159.36	187.88	$30.00 per month
Washington[7]: Basic Health Plan						
Unsubsidized (200% +FPL)	95.00	95.00	190.00	295.00	295.00	N/A—sold directly to individuals
Subsidized (100-124% FPL)	19.00	19.00	38.00	55.00	55.00	
AVERAGE FOR ALL PRODUCTS:						
Using Unsubsidized Rates						
Mean	78.46	80.44	168.32	220.51	222.41	
Standard Deviation	22.50	21.00	49.49	64.73	63.21	
Using Subsidized Rates						
Mean	66.45	68.44	142.75	185.41	187.31	
Standard Deviation	19.80	19.44	40.83	63.31	62.90	

[1] Rates are for premiums in effect as of March 31, 1989. Maine, Michigan and Washington states offer direct premium subsidies for low-income enrollees. Unsubsidized rates are for persons with incomes above 200 percent of the federal poverty level (FPL) and subsidized rates for those just above 100 percent FPL.

[2] Assumes a 2-person group is made up of employee & spouse age 35 and that a three or four person group has two adults plus children.

[3] Arizona: rates for Maricopa County.

[4] Denver: rates for Denver area.

[5] Michigan: rates for Genessee County.

[6] Utah: rates for groups of less than 15 employees.

[7] Washington: rates are statewide averages.

Coverage of Selected Benefits in 15 Health Insurance Plans*

Always Covered (15 products)

- **Doctor's Office Visits**
  Alabama Plans A & B: limit to 6 visits/year
  Denver: $15 copayment or 50% coinsurance if procedure performed
  Utah: $20 copayment for specialists

- **Outpatient Diagnostic X-Ray and Laboratory Testing**
  Alabama Plans A & B: $300/year maximum

- **Outpatient Surgery including doctor's charges and facility charge**
  Alabama Plans A & B: $50 copayment for facility
  Utah: $75 copayment for facility

- **Well Baby Care**

- **Ambulance**
  Alabama Plans A & B: covered only if admitted to hospital
  Denver: $100 limit for ambulance only

- **Emergency Room**
  Copayments ($25-$50) charged by two-thirds

- **Hospital Inpatient including semiprivate room and board, miscellaneous charges, surgeon's fees, anesthesiologist's fees, doctor's visits in the hospital and prescriptions**
  Alabama Plans A & B: 10 days/year limit, $20/day copayment
  Florida Standard: $100 copayment days 1-5
  Denver: 50% coinsurance
  Tennessee: $200 copayment per admission
  Utah: $150 copayment for days 1-4
  Washington: $50 copayment per admission

Almost Always Covered (14 products)

- **Outpatient Routine Physicals**

- **Outpatient Immunizations**

- **Outpatient Physical Therapy**
  Alabama Plans A & B: $2,000/year limit
  Denver: 50% coinsurance
  Maine: short-term therapy only, must improve significantly in 60 days
  Tennessee: 10 visits/year limit
  Utah: $20 copayment, must treat within 60 days of onset

- **Private duty nursing in the hospital**

Coverage of Selected Benefits in 15 Health Insurance Plans*

Usually Covered (10-12 products)

- **Outpatient Prescriptions (12 products)**
  Typically charge copayment of $3-$10
  Denver: 50% coninsurance, separate deductible of $50/year
  Maine: available only as a rider

- **Home Health Visits (11 products)**
  Denver: 50% coinsurance, 100 visits/year limit
  Tennessee: 60 visits/year limit

- **Routine Hearing Exams and Eye Exams (10 products)**

Sometimes Covered (6-8 products)

- **Convalescent Care, Skilled Nursing Facility (8 products)**
  Denver: 50 days/year limit per related cause, cover at 50% hospital room and board rate
  Florida Standard & High: 20 days/year, $25/day copayment for Standard
  Maine: 100 days/year limit
  Tennessee: 100 days/year limit
  Michigan Network: $25/day copayment

- **Mental Health - Outpatient (8 products)**
  Typically limit either number of visits (20 most common) or dollar amount ($1,000 or $2,000)
  Tennessee: available only as a rider

- **Mental Health - Inpatient (7 products)**
  Most have high copayments per day ($100-$200) or 50% coinsurance for limited number of days (usually 30 days)
  Tennessee: available only as a rider

- **Hospice Care (6 products)**
  Denver: 50% coinsurance, 6 month limit

Least Frequently Covered (1-3 products)

- **Durable Medical Equipment (3 products)**

- **Prosthetic and Orthotic Appliances (2 products)**

- **Podiatry (1 product)**

- **Genetic Testing and Counseling (1 product)**

*Table 9 lists benefits included in 15 insurance plans offered or approved by Health Care for the Uninsured Program projects. Limitations on these benefits are shown, including coinsurance rates of greater than 20 percent paid by the enrollee, copayments of greater than $10, and ceilings on the number of visits or total charges.

UNINSURED MONTANANS - PART II

The introduction of this report mentions that there are over 49,000 children under the age of eighteen in Montana without insurance coverage. The committee who examined children's health are issues chose to offer a private insurance plan that is being offered in 14 other states. The policy is entitled the Blue Cross Blue Shield Caring Program. There are three basic tenants to a successful "Caring Program." First, Blue Cross Blue Shield provides all administrative costs free of charge to the plan. Second, health care providers agree to offer services for a reduced fee. Finally, a non-profit foundation raises money to provide the monthly coverage for the children enrolled. (Note: A Montana plan is estimated to cost $25 per month per child.)

The following outline of the Caring Program provides further information about the plan's coverage and logistics.

OUTLINE OF MONTANA'S CARING PROGRAM FOR CHILDREN

Purpose:

- To provide immunizations and early diagnoses that may help prevent children from becoming seriously ill
- To maintain the health of children
- To provide emergency health care services

Benefits provided for children:

- Doctor well/sick office visits
- Emergency accident and medical treatment
- Out-patient surgical care
- Out-patient diagnostic tests
- Immunizations
- Prescriptions

Funding:

- Provided by contributions to the Caring Foundation of Montana, Inc., a nonprofit 501C3 subsidiary of Blue Cross and Blue Shield of Montana through individual, business, civic and community support.

Commitment:

- Blue Cross and Blue Shield of Montana, as their contribution, will donate all administrative and program costs for the Caring Program. This means that all donated funds -- 100% -- will be used to provide health care services for these children. This effort is in keeping with the Blue Cross and Blue Shield of Montana concept to make affordable health care available for all children of eligible families have an accurate cost measure for future budgeting based on actual usage.

Target:

- 500 children

How Can "YOU" Help THE CARING PROGRAM FOR CHILDREN?

* YOU can encourage your company or business to become involved by making a contribution to The Caring Program Foundation.

* YOU can encourage church communities and service organizations to become involved in sponsoring children in The Caring Program For Children.

* YOU can urge your employer and other employees to make contributions to The Caring Foundation of Wyoming, Inc.

* YOU can ask your family doctors and pharmacists if they are Caring Providers and if not, encourage them to participate.

* YOU can send your tax-deductible contributions to:

THE CARING FOUNDATION OF MONTANA

"SPONSORSHIP"

Civic/Community Groups
Churches
Businesses
Corporations
Unions
Youth Organizations
Individuals

The Caring Program For Children Can Help.

* The Caring Program is a program that.....

  "cares for children who can't afford to get sick"

* The Caring Program will begin to help meet the needs of these children by providing basic benefits for primary, preventive and emergency health care.

* Many medical crises might be prevented by earlier medical attention.

Who Provides This Care?

* Care will be provided through physicians, hospitals, clinics and pharmacies throughout Montana. These Participating Providers will agree to accept the Caring Program fees as **payment-in-full** for treating Caring Program children.

Eligibility Requirements

* An unmarried son/daughter, stepchild, or ward living with a legal guardian under the age of 18.

* A resident of the State of Montana.

* They must meet the program's family income guidelines.

* They must not be eligible for Medicaid, receiving other medical assistance insurance or any other public or private assistance.

Is There Any Cost To The Family?

* The Caring Program provides covered services to enrolled children. There will be no charge for obtaining the insurance for the child(ren).

How Many Children Can Enroll?

* The number of children served by The Caring Program For Children is limited only by the amount of dollars raised by the Foundation.

* Children will not be turned down for health reasons.

Where Does The Money Come From?

* From People Like YOU. sponsorships of enrolled children are funded by tax-deductible contributions from individuals, corporations and organizations.

* Avenues of Financial Support.....

II. CHILDREN'S ISSUES - KIDS COUNT

Two committees endorsed the KIDS COUNT project which is already partially implemented but will require legislative and budget authority to fully implement. The initial results have been promising and will be enumerated within Human Services Committee hearings. Further background information and committee recommendations are contained in the following pages.

Governor
Stan Stephens

FOR YOUR INFORMATION

MONTANA
DEPARTMENT OF SOCIAL AND
REHABILITATION SERVICES
P.O. BOX 4210
HELENA, MONTANA 59604

Julia E. Robinson
Director

Kids Count

Designed to promote health and prevent disease in infants, children, and adolescents by improving access to health care for pregnant women and Medicaid-eligible children

THE project is a cooperative effort among the Montana Departments of Social and Rehabilitation Services, Health and Environmental Sciences, Family Services, Institutions, and the Office of Public Instruction. Funding for this project is included in Governor Stephens' budget proposal.

Emphasizing prenatal and well child care through education, early intervention, and improved access reduces long-term costs by preventing disease and decreasing births of high-risk babies needing high-cost care. To accomplish this, Kids Count proposes a broad array of new and expanded services including:

- a statewide education campaign on prenatal care;
- improved access to obstetrical, pediatric, and dental care through expanded Medicaid eligibility and increased medicaid rates;
- early intervention services for children determined to be at risk of developmental delay; and
- incorporating the former Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) into "Kids Count."

Education & Access To Care Of Key Importance

A major focus of Kids Count is to enhance the health of mothers and children through education and access to prenatal care...the most cost-effective means of reducing both low birth weight and infant mortality. The average cost of providing prenatal care is $400, compared to lifetime costs of $400,000 or more to care for a low birth weight baby.

Through its contract with Healthy Mothers, Healthy Babies to administer the *"Baby Your Baby"* campaign, the Kids Count project includes a multimedia outreach and education campaign stressing the importance of early and continuous prenatal care and the need for healthy habits during pregnancy. A telephone hotline and referral system provide additional help and reinforcement.

Kids Count fills some financial gaps by: (1) increasing the Medicaid eligibility income level for pregnant women and children under age 6; (2) providing temporary Medicaid eligibility for pregnant women during review of their formal Medicaid application; and (3) providing continued Medicaid eligibility for 60 days post pregnancy. ■

"Emphasizing prenatal and well child care through education, early intervention, and improved access to health care."

For More Information Contact:
Nita Freeman
444-4540

Service Providers Encouraged To Participate

Achieving the goal of improved maternal and child health care means increasing the participation of Medicaid clients and providers. We cannot increase client participation without adequate access to obstetrical services. Low reimbursement rates, administrative paperwork, and the high cost of malpractice insurance are primary reasons cited by doctors for not participating in the Medicaid program. Compounding the impact of the low doctor participation rate, the number of doctors delivering babies in Montana declined 29% from 1986 to 1988. In January 1988, 18 of Montana's 56 counties had no obstetrical services, and another 19 counties anticipated losing obstetrical services in the near future.

To encourage health care providers to participate, Kids Count (1) increases delivery fees used in computing physician reimbursement; (2) reimburses rural health clinics and federally-qualified health centers for ambulatory services; and (3) seeks to increase reimbursement to alternative health care providers such as nurse-midwives and nurse practitioners.

Early Intervention A Key To Success

Expanding early intervention for children at risk of developmental delay is another key component of Kids Count. Early intervention encourages normal development patterns and prevents diagnosed conditions from becoming more disabling. While early intervention can prevent or ameliorate severe disability, not all Montana children receive the full range of services they need. About 100 Montana families now receive some early intervention service. Kids Count seeks to expand early intervention to offer a full range of services to the 550-600 Montana children under the age of three who are eligible under the Education of the Handicapped Act.

The Kids Count screening exam has also been expanded to comply with OBRA to remove barriers to care and expand services for diagnosis and treatment. The screening exam includes: (1) a comprehensive medical history; (2) a physical examination including nutrition and development assessment; (3) a vision and hearing screen; (4) a dental examination; (4) routine lab tests (lead, anemia, tuberculosis, etc.); (5) required immunizations; and (6) a yearly visit to the dentist for children age 3 or older.

Fiscal Impact Significant

Montana has approximately 25,000 Medicaid-eligible children. About one-half of them are currently screened through the early prevention services of Kids Count. The cost of medical care needed by children who have participated in early screening is up to one-third less than the costs of unscreened children.

The results of Kids Count are so successful that SRS Medicaid Services is working to involve all Medicaid-eligible children through expanded outreach activities. Kids Count clearly demonstrates that children with access to early preventive screening, diagnosis, and treatment are generally healthier with fewer medical needs and expenses than children without access. As an effective preventive health services program, Kids Count saves the state substantial long-term expenditures. ■

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KIDS COUNT RECOMMENDATIONS

RECOMMENDATION #1

Kids Count - Study the feasibility of outstationing eligibility staff at locations other than welfare offices, such as hospitals and other health clinics.

RECOMMENDATION #2

Kids Count - Increase reimbursement for delivery services to 90% of the average customary charge for the service. This would increase the global fee for a normal delivery to $1,235. This level of increase should be sufficient to meet the federal requirement that services must be available to Medicaid clients to at least the extent they are available to the general population.

RECOMMENDATION #3

Kids Count - Implement a targeted case management system for women who are identified by assessment to be at high risk of not delivering a full-term baby. The Medicaid program could reimburse eligible contract providers for case management services.

Potential providers of case management services would be DHES low birth weight clinics; migrant health clinics; urban Indian Health (IHS) clinics and IHS clinics for special needs population.

RECOMMENDATION #4

Kids Count - Develop strategies for continued funding of current low birth weight (LBS) projects and expand to additional sites as part of the MIAMI Project expansion.

RECOMMENDATION #5

Kids Count - Continue education efforts to pregnant women on the importance of the "Baby Your Baby" project and encourage agencies to help fund a "corporate sponsorship" of this project.

RECOMMENDATION #6

Kids Count - Adopt the American Academy of Pediatrics Screening Schedule for the EPSDT program increasing the number of screens from 12 to 20 during the first 21 years of life.

RECOMMENDATION #7

Kids Count - Increase public awareness and child-find activities throughout the state.

The Part H infant and toddler program, requires participating

states to inform the public about the statewide early intervention program and the child-find system, including how to make referrals and how to gain access to evaluation and services. The child-find system should set up an effective method for hospitals, physicians, parents, day care programs and other providers to refer children to the early intervention system for evaluation and assessment.

To ensure a true interagency approach to child-find activities, the system must provide for coordination among the state's special education child-find program, the Maternal and Child Health program, Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, state developmental disabilities programs and Head Start.

RECOMMENDATION #8

Kids Count - Demonstrate increased interagency cooperation through the development of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.

Special emphasis should be placed on the development of coordinated strategies to locate children with disabilities or at risk of becoming disabled as soon after birth as possible.

Information gathered through the Department of Health and Environmental Sciences' Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Project and the "Baby Your Baby" public education project should be utilized as a basis for development of a risk registry. Other agencies would need to cooperate with this effort and enter into agreements that would allow for sharing information while at the same time protecting the confidentiality rights of Montana's citizens. Specific tracking and follow along procedures could be developed utilizing the public health system already in place in the counties throughout the state.

RECOMMENDATION #9

Kids Count - Enter into formal interagency agreements with other state-level agencies involved in the state's early intervention program.

Each agreement should define the financial responsibility of the agency for paying for early intervention services, include procedures for resolving intra- and interagency disputes and any additional components necessary to ensure effective cooperation and coordination among all agencies involved in the state's early intervention program.

RECOMMENDATION #10

Kids Count - Make the policy commitment required by PL 99-457 to implement a statewide, comprehensive, coordinated, interagency, multidisciplinary system of early intervention services for infants and toddlers with handicaps and their families.

In order to continue to receive federal Part H early intervention grant funds and maintain services to approximately 100 Montana families using Part H dollars, the State of Montana must make a policy commitment to fully implement Part H and provide the full menu of services called for by the federal legislation. Such a commitment will require a further appropriation of state funds in FY 92-93 as well as improved utilization of existing federal, state and local resources.

A conservative definition of "developmental delay" such as the one tentatively adopted by DDD to determine eligibility for Part H services would make approximately 1.5 percent of the Montana children under the age of three years of age eligible to be served. Currently 210 children under 36 months of age receive some, but not all of the required services. The proposal to fully implement Part H will provide the level of early intervention and family support services required by Part H to children currently in the program as well as those eligible children yet to be located, evaluated and served. The projected cost to the state general fund for the full implementation of the Part H infant and toddler program is $1,180,000 in FY 92 and $1,380,000 in FY 93.

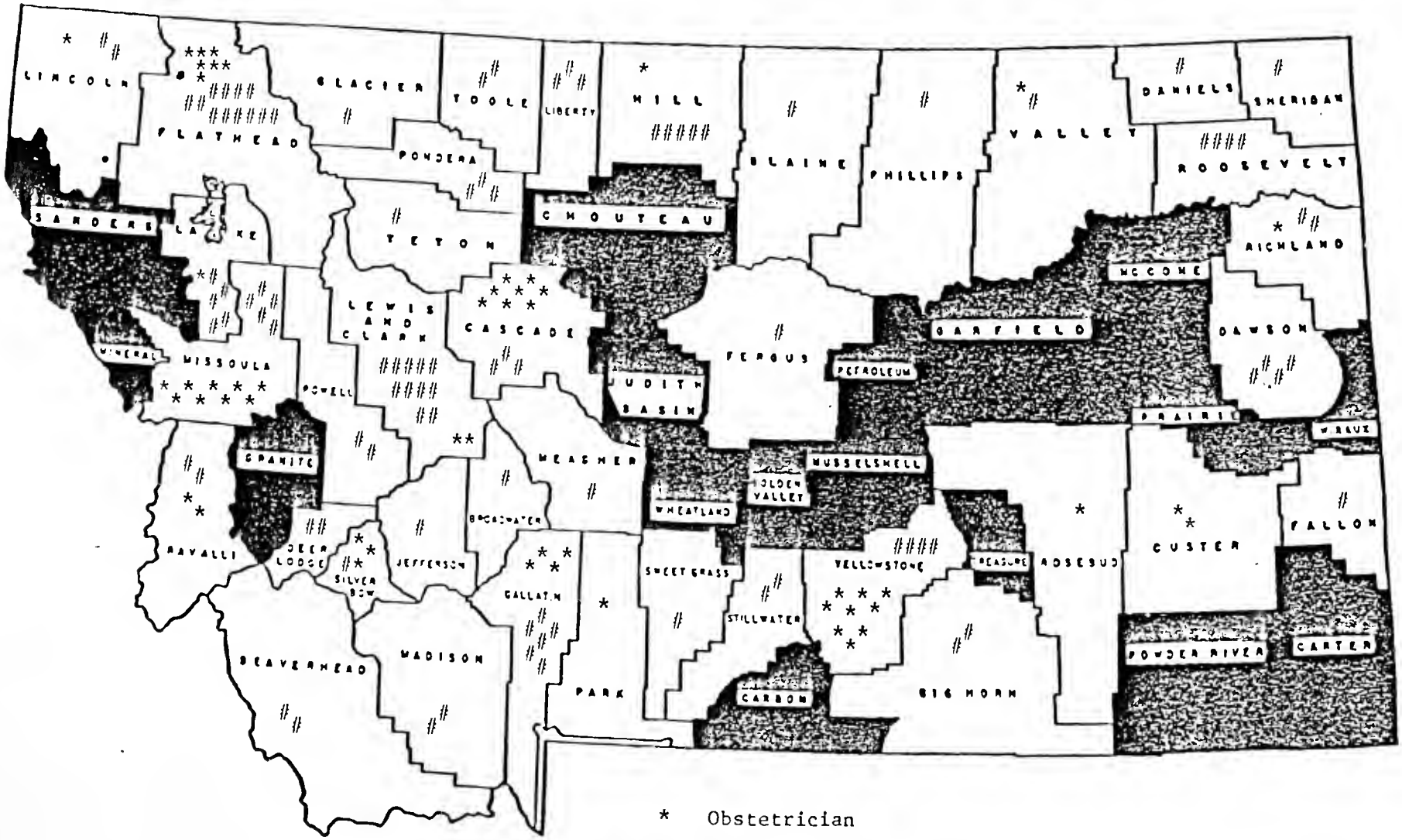
RECOMMENDATION #11

Kids Count - Establish a State Center for Health Statistics (SCHS) housed in DHES. The SCHS would be responsible for collection and storage of data, compiling required reports and disseminating identified data profiles on a periodic basis. The U.S. Public Health Service, Centers for Disease Control, would provide the standards and federal coordination and reporting requirements.

Appendix 1

Charts and graphs highlight many of the problems Montana has faced in providing health care to children.

MONTANA COUNTIES WITHOUT OBSTETRICAL SERVICES 1990



* Obstetrician

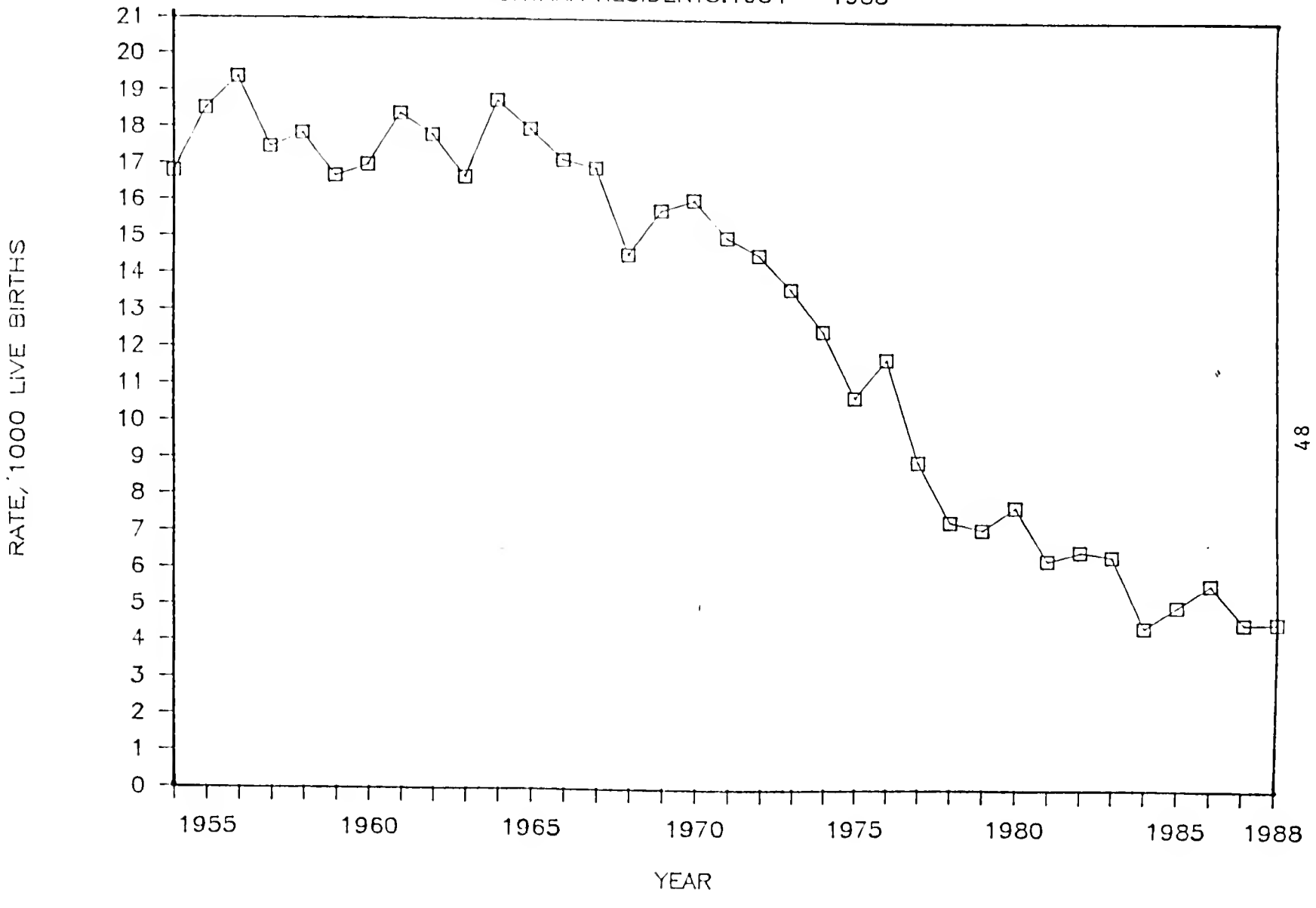
\# Family Practitioner

■ No Obstetrical Services (17 counties - 37,025 square miles)

Source: MT Academy of Family Practitioners
MT Medical Association
MT Perinatal Program (DHES)

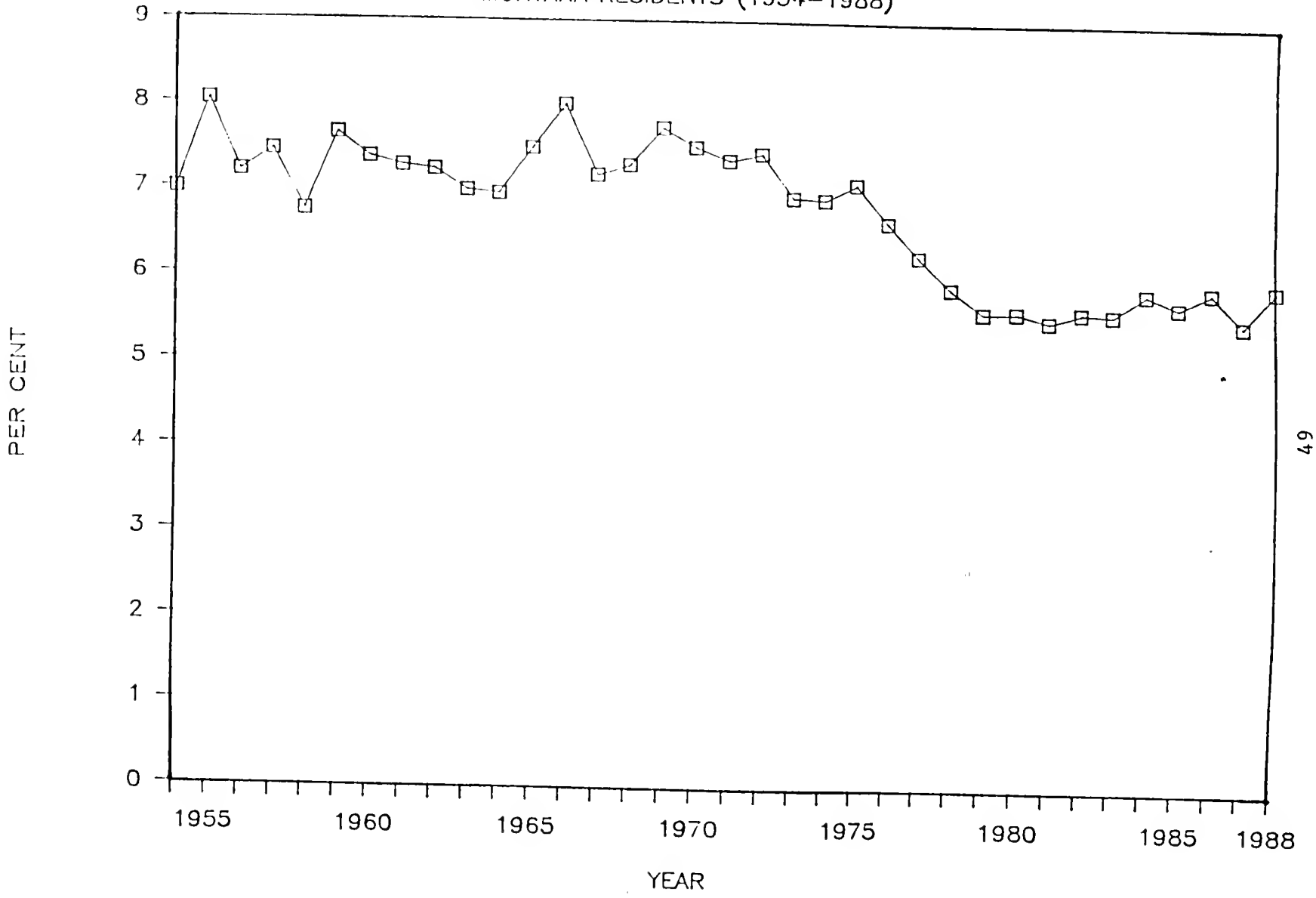
NEONATAL DEATH RATES

MONTANA RESIDENTS:1954 – 1988



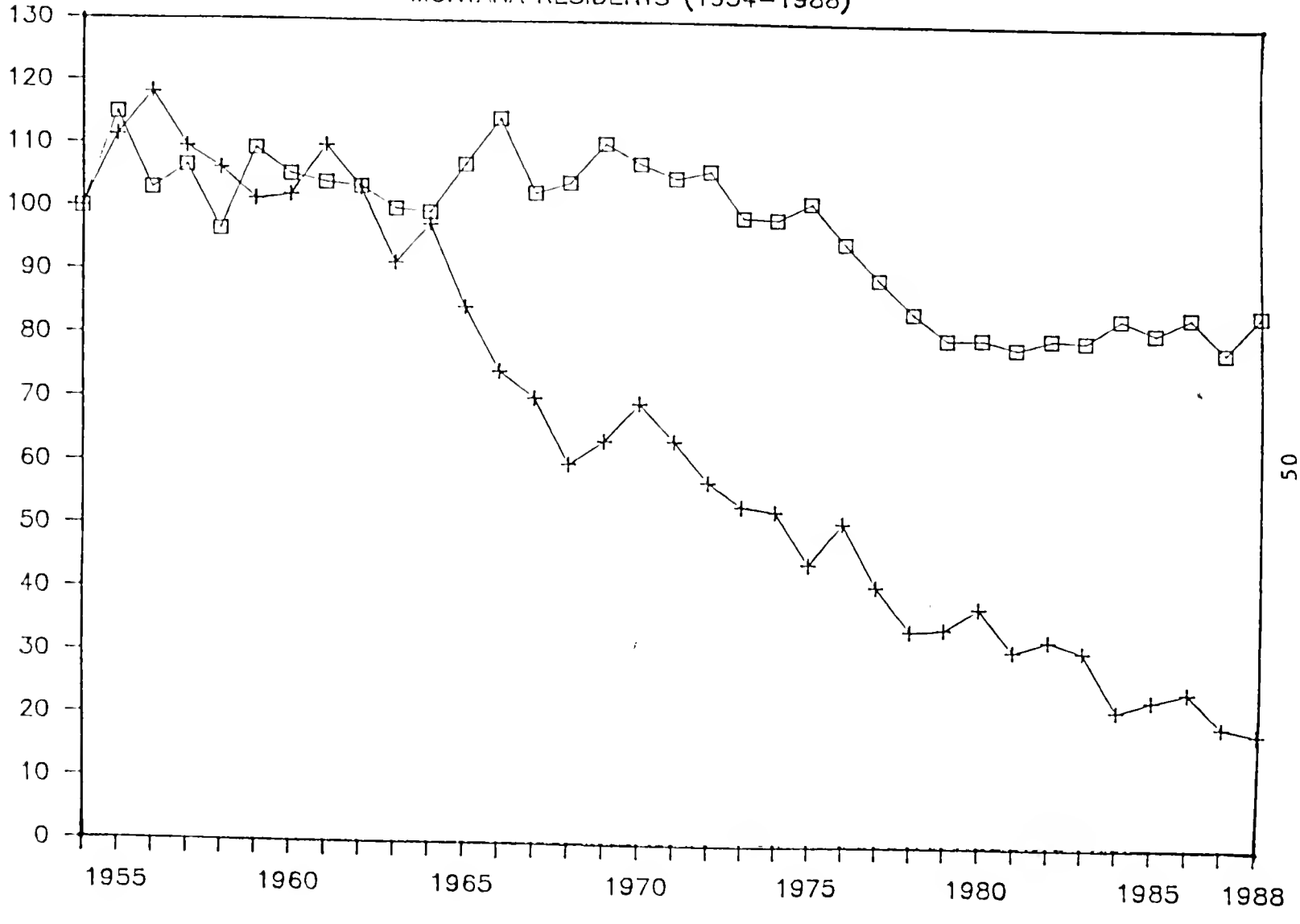
LOW BIRTH WEIGHT BIRTHS

MONTANA RESIDENTS (1954–1988)



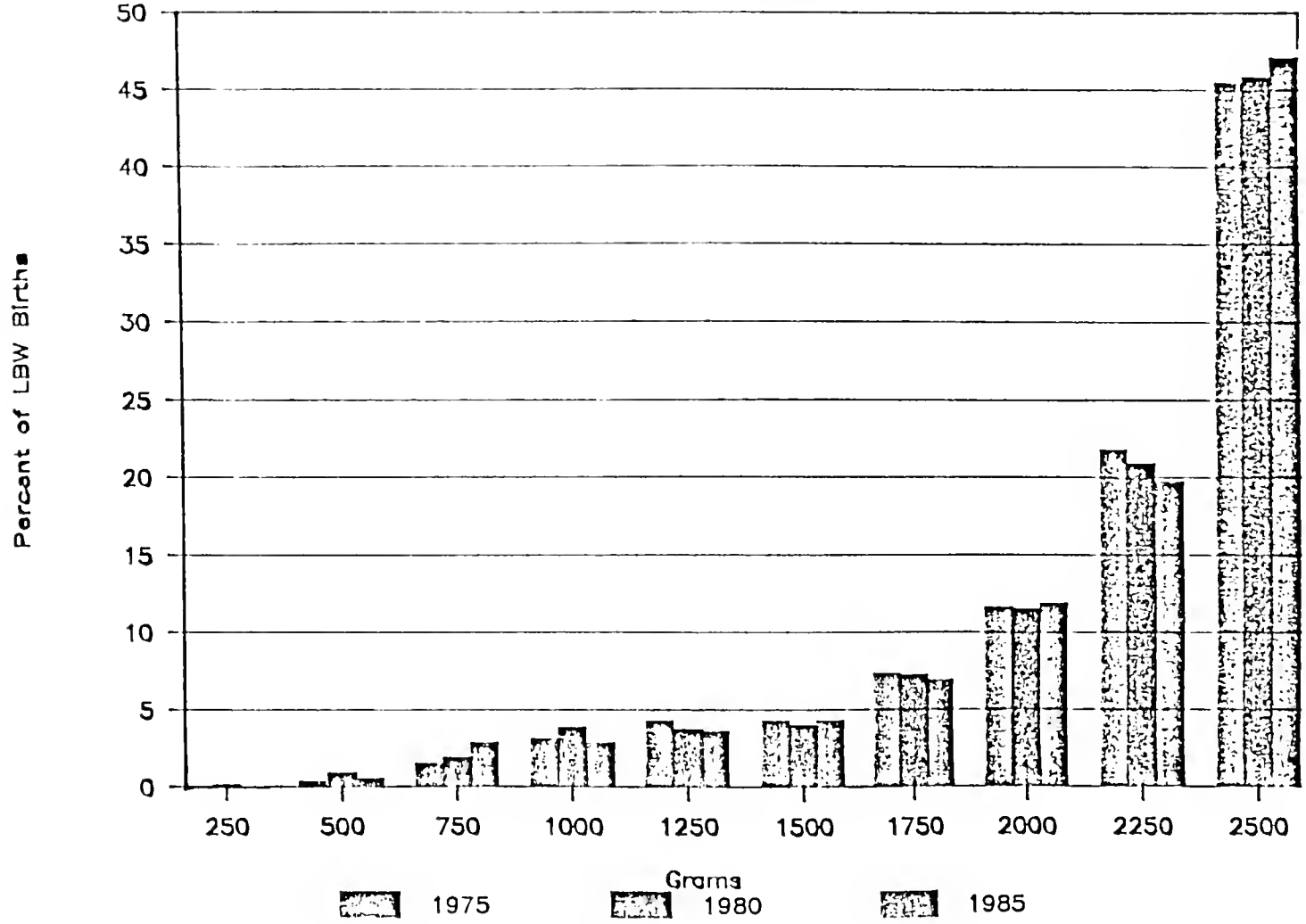
NEONATAL INDEX & LOW BIRTH WEIGHT INDEX

MONTANA RESIDENTS (1954–1988)



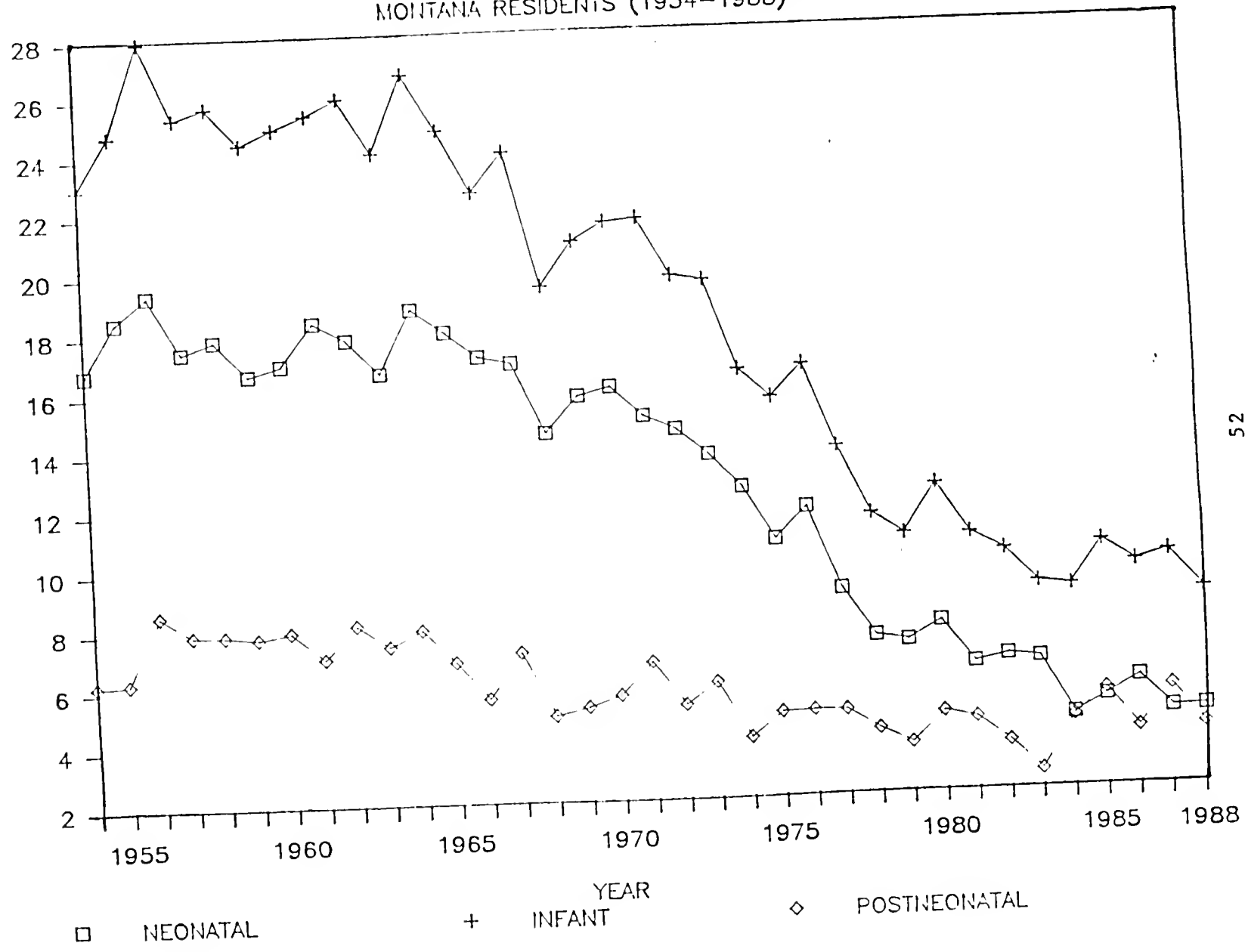
LOW-BIRTH-WEIGHT DISTRIBUTIONS

Montana 1975, 1980 and 1985



RATES:NEONATAL,POSTNEONATAL&INFANT

MONTANA RESIDENTS (1954–1988)



II. CHILDREN'S ISSUES - IMMUNIZATIONS

Immunizations have been shown to be among the best of preventive and cost effective treatments available. The state has a long history in providing vaccines to clinics to immunize children. Records show that Montana has always distributed its share of federal allocations of vaccine. During several committee meetings the issue of insufficient amounts of vaccine was brought forth by both committee members and persons in attendance. Because the issue could not be resolved within the timeline available the following recommendation was put forth to the Governor.

There is growing concern in the state that Montana's immunization program is not adequately funded to meet current needs. It is becoming increasingly apparent that additional resources need to be spent to fund the costs of new vaccines or to allow private physicians to offer state financed vaccines through their offices. Furthermore, the state should address the problems of vaccine distribution with both public and private sources. An immunizations committee review of this issue indicated that the Department of Health met all requests last fiscal year. This did not, however, include new vaccines or physician usage. The committee strongly believes that vaccinating children is a cost-effective method of reducing health risks and subsequent health care costs. In order to encourage the broadest vaccination of Montana's children possible, this committee recommends that the State Board of Immunization develop a comprehensive plan for providing immunizations and that the Department of Health present the plan in full to ensure that the Legislature and Governor will have an accurate cost measure for future budgeting based on actual usage.

II. CHILDREN'S ISSUES - THE MIAMI PROJECT

The MIAMI Project is one of the true success stories enacted by the 1989 legislature. The Health Care AVailability Advisory Council recognized this and recommended that the MIAMI Project be continued. It is due to sunset in June of 1991. The following report outlines the accomplishments that the MIAMI Project has made and the recommendations for the future.

Montana's Initiative for the Abatement of Mortality in Infants

M I A M I

CONTENTS

EXECUTIVE SUMMARY
Accomplishments and Recommendations

INFANT MORTALITY: A GROWING CONCERN

The death of an infant is a profound human tragedy. Each year, some 40,000 American infants die before their first birthday. The rate of infant death is a major standard, accepted throughout the world, for measuring a society's overall health status and a nation's health and well being.

As a society, we have made great gains in ensuring the survival of our infants and improving the quality of their lives. However, among industrialized nations, the U.S. has one of the highest rates of infant mortality (9.9 deaths per 1,000 live births in 1988), ranking 19th behind such countries as Singapore, Hong Kong and Spain.

In Montana, a low birth weight baby is born every 12 hours and every 3 days one baby under one year of age dies.

The high U.S. mortality rate is brought about largely by low birth weight babies (LBW) being born too soon or too small (from prematurity or from not growing adequately during pregnancy), and by increases in infant death rates during the first year of life (postneonatal mortality). During this period babies are most vulnerable to damaging effects of poverty and inadequate health care.

Care for pregnant women is at most a 10 month commitment. SHORT TERM COMMITMENT REAPS LONG TERM BENEFITS.

THE "MIAMI" CONCEPT

Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) was developed to address issues critical to the well being of pregnant women, women anticipating pregnancy, and children. Despite our "low risk" (primarily Caucasian) population, in 1987 Montana ranked 29th in the nation in infant mortality, down from our 20th rank in 1986. The major reason Montana babies die before their first birthday is low birth weight. The most effective tool to decrease the incidence of low birth weight is early, comprehensive and continuous prenatal care.

For further information and copies of the complete report, contact the Montana Perinatal Program (MPP), Family/MCH Bureau, Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. Phone (406) 444-4740.

The MIAMI concept faces those issues identified nationally, and encompasses the best of what has been learned in Montana and recommended nationally. Goals of the MIAMI project are:

The MIAMI project builds on the concept that the whole is greater than the sum of the parts.

- assuring that mothers and children, regardless of income or availability of health services, receive access to quality maternal and child health services;
- reducing infant mortality and the number of low birth weight babies; and
- preventing the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care.

A seven-member MIAMI Advisory Council was appointed by Governor Stephens to advise the Montana Department of Health and Environmental Sciences (MDHES) on "matters pertaining to the MIAMI project and to make recommendations regarding maternal and child health services." Members of the Council include:

Marietta Cross, R.N., Missoula, Chairperson, representing a non-profit child health organization (Healthy Mothers, Healthy Babies);
Jeffrey Hinz, M.D., Great Falls, pediatrician, representing the medical profession;
Cherry Loney, Great Falls, Health Officer, Cascade City-County Health Department, representing local health departments.
Lil Anderson, Billings, Associate Director, Yellowstone City-County Health Department, representing a local service provider;
Nancy Colton, Bozeman, parent, representing a parent support group;
J. Dale Taliaferro, Helena, Administrator, Health Services Division, representing MDHES; and
Nancy Ellery, Helena, Administrator, Medicaid Services Division, representing the Montana Department of Social and Rehabilitation Services (MDSRS).

MIAMI ADVISORY COUNCIL

Marietta Cross, R.N., Chairperson, Missoula
Jeffrey P. Hinz, M.D., Great Falls
Cherry Loney, R.N., Great Falls
Lil Anderson, R.N., Billings
Nancy Colton, Bozeman
J. Dale Taliaferro, Helena
Nancy Ellery, Helena

MIAMI PROJECT/MPP STAFF

Maxine Ferguson, Bureau Chief, Family/MCH, MDHES
Jo Ann Dotson, Nurse Coordinator, MPP
Cindy Little, Admin. Assistant, MPP
Sidney C. Pratt, M.D., Medical Advisor

Four components make up the MIAMI Project. They are:

- Low Birth Weight Prevention
- Infant Mortality Review
- Medicaid Changes for Pregnant Women
- Public Education ("Baby Your Baby")

Descriptions of each component and accomplishments to date appear on the following pages.

LOW BIRTH WEIGHT PREVENTION

Low birth weight prevention services utilize a care coordination approach based on screening eligible pregnant women for medical and/or psychosocial risk of preterm labor or low birth weight; assisting these women to access prenatal care, preferably during the first trimester of pregnancy; education about signs and symptoms of preterm labor; education and assessment of the use of alcohol, tobacco and other drugs; assessment of nutritional status and risk; referral to WIC, other agencies and programs for services, treatment, and other assistance. A program model identifying these components has been developed and is utilized by local projects.

DEFINITIONS:

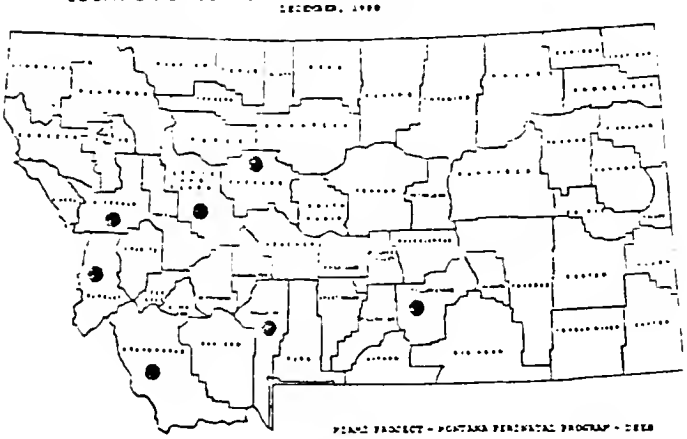
Low Birth Weight (LBW) -2500 grams (5 lb., 8 oz.) or less;

Very Low Birth Weight (VLBW) - 1500 grams (3.3 lbs.) or less.

Low birth weight prevention projects are located in public health departments or hospitals in seven counties where approximately 50% of Montana's births occur. Nearly 1,350 women received services from the projects during the past year. Locations of these services are shown on the map.

Many factors interact to produce a low birth weight baby. These include environment, culture, politics, economics and health systems as well as social class factors, health behaviors, access to prenatal care, stress, age, race, marital status, education, maternal complications and preterm labor.

LOCATION OF LOW BIRTH WEIGHT PREVENTION PROJECTS



A total of $152,150 for the 7 projects was administered by the Montana Perinatal Program during FY '90. This does not include funding provided by local health departments and hospitals in support of these projects.

Low birth weight prevention projects are impacting Montana babies. Only 4.92% of births to project clients were low birth weight, compared to a pre-project rate of 9.2%.

Sources of state-administered funds included Federal Maternal/Child Health and Preventive Health Block Grants and State General Fund dollars. Costs per client are shown in the table below.

Table 1
Funds Contracted for LBW Prevention Projects
and Costs Per Client Served

Data Sources: Project Application/Contracts

Total Funding to Projects	$152,250.00
Number of Women Served	1,341.00
Cost/Client	$ 113.46

$113.46 of state-administered funds can save approximately $32,558 in acute care costs when used to prevent one "high cost" baby.

In Montana, a low birth weight baby costs a minimum of $610 per day and may be hospitalized 7 to 20 days. A very low birth weight survivor (one who eventually goes home) averages $31,000 to $71,000 in hospital costs alone. Very low birth weight infants are more likely to have problems requiring lifetime care. Lifetime costs for a VLBW infant average $415,588.

Several sites were able to determine the rate of low birth weight among client populations prior to beginning a low birth weight prevention project. Based on current LBW rates, the number of LBW babies prevented were calculated for four sites. Potential savings by these prevention efforts are shown in the table below.

Table 2

Cost Savings of Four Projects Through LBW Prevention

Project	Projected LBW Babies*	Actual LBW Babies	Number of LBW Babies Prevented	Acute Care Savings•
A	9	5	4	$130,232
B	2	1	1	32,558
C	22	9	13	423,254
D	19	12	7	227,906
		TOTAL POTENTIAL SAVINGS		$813,950

* *Number of LBW babies which would have occurred to FY'90 LBWPP clients if calculated at preproject rates*
• *Based on figure from Montana SRS "High Cost Babies" study, 1983.*

"Studies have documented that indigent women have better outcomes as a result of prenatal care in organized, publicly supported settings such as health departments and community health centers. . . ."

A wallet card listing signs of preterm labor has proved successful in educating pregnant women.

The Wall Street Journal [June 24, 1988] concluded that for each week of prematurity prevented, a company may save as much as $10,000 in insurance costs. In an article titled "What Price Prematurity?", Rachel Schwartz calculated costs saved by the upward shifting of infants into the next higher birth weight category. Postponing delivery through monitoring and early detection of two 800 gram infants (approximately 1 lb., 12 oz. each) even for one week may result in savings of up to $33,700. These figures underscore the importance of educating pregnant women about the signs and symptoms of preterm labor.

The care coordination approach's success is demonstrated in one project's quarterly report, which states:

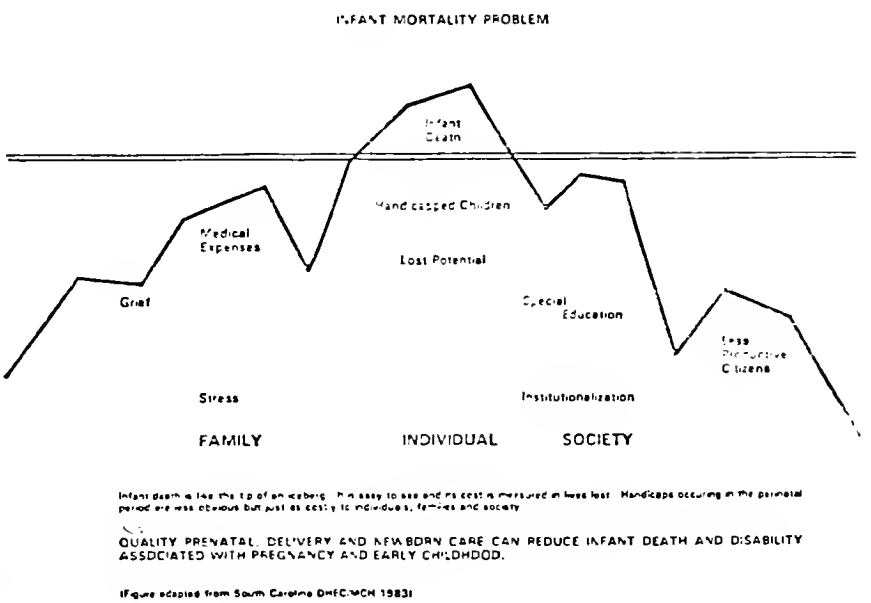
> *"Kate" went into preterm labor at 25 weeks due to premature rupture of the membranes. She was hospitalized for a total of ten days and was sent home on oral [medication] and strict bed rest for the duration of pregnancy. . . . The community health nurse provided support and education throughout "Kate"'s difficult pregnancy. . . . "Kate" delivered a healthy baby boy at 39 weeks . . ."*

Successful as the care coordination model for low birth weight prevention has been, it does not tell the entire story. Community changes are evident in each area where a low birth weight prevention project has been in existence for two or more years. Community coalitions composed of persons from many agencies and organizations concerned with improved care for mother and children are working together. Referrals to the projects have increased, both in number of women referred and source of referrals. Creative approaches to educating clients about preterm labor have been developed. One example is a wallet size card which lists the signs of preterm labor.

INFANT MORTALITY REVIEW

Infant mortality has a major impact on the lives of all Montanans. The tragedy of death, while devastating to the family and friends, is actually only the tip of the iceberg. As depicted in a model developed by South Carolina (Figure 1), its impact on society is actually only the most visible effect, with family stress, medical costs, special education needs, and lost potential affecting the society in many other ways. The problem requires careful study, so that not only the actual deaths may be reduced, but also the other consequences may be decreased.

Figure 1



Infant death is like the tip of an iceberg. It is easy to see and its cost is measured in lives lost. Handicaps occurring in the perinatal period are less obvious but just as costly to individuals, families and society.

QUALITY PRENATAL, DELIVERY AND NEWBORN CARE CAN REDUCE INFANT DEATH AND DISABILITY ASSOCIATED WITH PREGNANCY AND EARLY CHILDHOOD.

(Figure adapted from South Carolina DHEC/MCH 1983)

Fetal and infant mortality is more than a medical problem; socio-economic impacts cannot be ignored. According to a 1986 Innovations report, government has begun to enter the arena of health care delivery to infants and pregnant women, " because there are . . . people who are in great need of perinatal and maternal care that is unavailable due to cost, ignorance, or lack of accessibility." The report further states that "the mere presence of medical services does not necessarily mean that they are available and will be used by all people. Indeed, the primary obstacles for indigent patients are cost and lack of accessibility."

- What are the obstacles resulting in Montana's high mortality rates?
- How much do we really know about pregnant women's perceptions of health care, and reasons for their health care practices?
- But most importantly, WHY ARE MONTANA'S BABIES DYING?

WHY ARE MONTANA'S BABIES DYING?

INFANT MORTALITY REVIEW:

A process for examining factors which contribute to infant death through a systematic evaluation of individual cases in order to identify potential opportunities to maternal and infant health.

--William Sappenfield M.D.

DEFINITIONS:

Infant = child aged 1 year and under

Neonate = child aged 28 days and under

Postneonatal = period of time from age 29 days to 1 year

Fetal death = The birth of a fetus after 20 weeks gestation which shows no evidence of life after complete birth.
(Montana Vital Statistics definitions)

"A child doesn't have to be in a wheelchair to have a birth defect. Limiting a child's full potential, even by a small amount, is going to have an effect on society."

Lawton Chiles, Chairman
National Commission to Prevent Infant Mortality

These questions are the impetus for Montana's ongoing work on infant mortality. Montana's infant mortality rate of 11.3 in 1989 is our highest since 1980, and represents a 31 % increase from the 1988 rate of 8.6. (See Table 3) While this figure may be only a "blip" on a statistical screen, it does serve as a reminder to all concerned with the welfare of our children that infant deaths in our state are still a major problem.

Montana's 1989 infant mortality rate among Native Americans is over double the rate of infant mortality in the Caucasian population.

Table 3

Montana Statistics

Year	Live Births	Infant Deaths	Infant mortality rate (Deaths per 1000 births)
1989	11667	132	11.3
1988	11682	100	8.6
1987	12239	121	9.9
1986	12728	122	9.6
1985	13497	139	10.3
1984	14141	125	8.8
1983	14054	126	9
1982	14538	147	10.1
1981	14309	153	10.7
1980	14208	176	12.4

Montana's Native American infant mortality rate of 25.2 in 1989 is extremely high, rivaling the rates reported in minority populations in large urban settings in other states. The initial response to dismiss these figures as a result of low numbers or other reasons unique to Montana must be suppressed; North Dakota, a bordering state with many similar characteristics including weather, access, and population, had the best ranking in infant mortality among the 50 states in 1986, compared to Montana's dismal 20th ranking.

The MIAMI legislation (MCA 50-19-301 to 323) mandated the MDHES to conduct an Infant Mortality Review (IMR). Prior to the mandate, the MDHES contracted with Drs. Fred Reed and William McBroom of the University of Montana Center for Population Research to conduct research on the infant mortality issue. Their data set includes over 84,000 birth certificates for the time period from 1980 through 1985 and the linked birth-death certificates for that same time period. Their research made it very clear that further evaluation was needed, and data sources beyond the birth and death certificates were also needed.

In July of 1990, the MDHES began infant mortality review which reflects Dr. Sappenfield's definition requiring individual case review. Three counties, selected because of their size, interest, and ability to fund data collectors, have been participating on a voluntary basis in data gathering during a 6 month pilot study (July 1990 through December 1990). Although urban Native American babies are included in the current study, expansion plans need to include Indian infant mortality in all settings.

MEDICAID CHANGES FOR PREGNANT WOMEN

In 1984, 17 percent of women of reproductive age lacked insurance to pay for prenatal care and another 9 percent had only Medicaid coverage. . . As of 1985, the United States had made virtually no progress in meeting the goals set in 1980 by the Surgeon General for (1) reducing the percentage of babies born with low birth weight to no more than 5 % of live births and (2) ensuring that 90% of pregnant women obtain care within the first 3 months of pregnancy. *A substantial Medicaid effort, linked with other programs, can help to erase this country's poor performance among industrialized nations in terms of infant mortality. The effort can also help to reduce the disgracefully high infant mortality rates currently found among minorities.*

Under the auspices of the Governor's Human Services Sub-Cabinet, a subcommittee on Maternal Child Health was appointed. Their first report, KIDS COUNT, included MCH issues and initiatives, along with recommendations. Expanding medicaid eligibility for pregnant women and increasing access to providers through fee improvements are among the issues included:

- Increasing the eligibility income level to 133% of the federal poverty level (FPL) was implemented on April 1, 1990.
- Implementation of "presumptive eligibility" is targeted for January 1, 1991.
- "Continuous eligibility" is also targeted for implementation on January 1, 1991.
- Statewide, eligibility staff have been educated about the importance of early prenatal care and are expediting Medicaid applications for pregnant women.
- Outstationing eligibility staff has been determined unfeasible at this time.
- Increasing the eligibility income level to 185% of the federal poverty level will require state legislation.
- Reimbursement for delivery services has been increased to $756-$806, approximately 42% of usual and customary charges.

DEFINITIONS:

Presumptive eligibility - allows qualified providers to certify Medicaid eligibility for pregnant women while a formal application is being processed.

Continuous eligibility - allows Medicaid eligibility to continue in cases where the pregnant woman would no longer be eligible for financial assistance based on a change in income.

In 1988, Montana Medicaid spent $4.2 million (51% of the total delivery budget) on only 4% of the births. A majority of the births were low birth weight which could have been prevented with early, regular prenatal care.

Medicaid pays an average of $19.48 for each prenatal visit. Compare that cost to neonatal intensive care costs of $610 - $2000+ per day!

PUBLIC EDUCATION -- "BABY YOUR BABY"

One of the answers to improved infant health and survival is the development of a multi-media awareness and public education campaign that will communicate with expectant mothers. The "Baby Your Baby" (BYB) campaign is designed to educate and motivate expectant mothers (and those who care about them, i.e., relatives, friends, parents) to enroll in a medical support program in the first trimester of pregnancy.

"Baby Your Baby" is directed primarily to high risk women. Specific target groups include teenagers, alcohol and/or drug addicted or affected women, and low socio-economic groups, including the homeless.

Many public and private organizations are supporting the BYB campaign through funding or other support. **Major funders** have contributed $7500 or more to the campaign effort. **Sponsors** also provide funding for the campaign. **Endorsing organizations** support the concept and approaches of the campaign, and recognize the importance of educating the public about the needs of pregnant women.

Elements of the statewide campaign include, but are not limited to television and radio public service advertising, print advertising, billboards, posters, video documentaries, television news series and insert segments, newspaper tabloids, incentives and referrals. A toll free information line (1-800-421 MOMS) has been established so women can register for the program. Airing of the television and radio spots will begin in January 1991.

Public/Private Partnership

The BABY YOUR BABY campaign is a public\private partnership. The cost of the campaign is being underwritten by sponsors from both the public and private sectors.

Securing funding and developing contracts for service have occupied a major portion of the past year. A contract has been developed between MDHES and Healthy Mothers, Healthy Babies for conducting the education campaign, in response to a Request for Qualifications issued by MDHES. Other contracts and agreements permit Medicaid match of state general funds and all private sector donated funds. HMHB purchased program rights from the Utah Department of Health and KUTV in Salt Lake City, established KTGF in Great Falls as the program originator and network anchor in Montana, and has retained a technical advisor, a public relations firm and a production company.

Brochures about health services, child care, pregnancy care and social service programs make up an information packet which will be mailed to women who register in the BABY YOUR BABY program. Incentives designed to attract expectant mothers into the program have been field tested. The registration also serves as a referral and tracking system.

Community forums held in 17 Montana cities in November and December of 1990 informed health care, social services and other community professionals about the program, and even more important, assisted communities in developing local activities and referral services for the BYB campaign.

Careful evaluation of the project will be done so that the findings can be utilized by MDHES, MDSRS, HMHB and others.

BYB Major Funders

- *Blue Cross and Blue Shield of Montana*
- *Healthy Mothers, Healthy Babies — The Montana Coalition*
- *St. Peter's Community Hospital, Helena*
- *State of Montana*
  - *Department of Family Services*
  - *Department of Health and Environmental Sciences*
    - *Family/MCH Bureau*
    - *Perinatal Program*
    - *WIC Program*
    - *Immunization Program*
  - *Department of Social and Rehabilitation Services*
    - *Child Support Enforcement Bureau*
    - *Medicaid Division*
    - *Developmental Disabilities Division*

BYB Sponsors

- *Children's Trust Fund*
- *Dr. Leonard Kaufman*
- *Kiwanis of Helena*
- *March of Dimes, Montana Big Sky Chapter*
- *Montana Medical Genetics Program — Shodair Hospital*
- *Montana Area Health Education Center*
- *The Doctors' Company*

BYB Endorsing Organizations

- *Local health departments*
- *Local HMHB coalitions*
- *Montana Academy of Family Physicians*
- *Montana Academy of Pediatrics*
- *Montana Children's Alliance*
- *Montana Hospital Association*
- *Montana Council for Maternal Child Health*
- *Montana Medical Association*
- *Montana Medical Auxiliary*
- *Montana Nurses' Association*
- *Montana Section - American College of Obstetricians and Gynecologists*
- *Montana Section of Nurses Association of the American College of Obstetricians and Gynecologists*
- *Montana State Governor's Office*

Date of report release: 12/90

RECOMMENDATIONS OF THE MIAMI ADVISORY COUNCIL

1. **Extend the sunset on MIAMI legislation to June 30, 1993.**

2. **Create a state center for health statistics, which will facilitate the retrieval of information needed to guide health provision and planning.**

3. **Develop a rural health planning commission, which will provide support and consultation to rural health practitioners, as well as guide state planning for rural health provision.**

4. **Encourage policy changes which will improve health care of infants and pregnant women through tort reform.**

5. **Support the Montana Medical Genetics program.**

6. **Support the public vaccine program so that no child will be denied vaccine and potentially pass preventable illnesses on to women and/or their fetuses.**

7. **Facilitate the creation of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.**

LOW BIRTH WEIGHT PREVENTION

8. Accommodate increased client loads by additional funding to the existing seven (7) low birth weight prevention projects.

9. Contingent on adequate funding of existing projects, fund an additional nine (9) low birth weight prevention project sites.

10. Facilitate the role of mid-level health care providers in Montana.

11. Collaborate with Indian Health Services, tribal health and urban Indian centers to improve coordination of services to Native Americans.

12. Facilitate home visits for all high risk and/or first time mothers.

13. Increase referrals of Low Birth Weight Prevention Project clients to local family planning clinics and other applicable services.

INFANT MORTALITY REVIEW

14. Expand infant mortality review to additional sites, including more locations where Native American populations may be accessed.

15. Fund expansion of the review process to include low birth weight births, to allow examination of causes of infant morbidity.

MEDICAID CHANGES FOR PREGNANT WOMEN

16. Expand Medicaid eligibility coverage for pregnant women and children up to age six to 185 percent of the federal poverty level.

17. Increase reimbursement for prenatal and delivery services to 90% of actual fee.

18. Implement a targeted case management system for high risk pregnant women.

19. Maintain presumptive and continuous eligibility as a Medicaid priority.

20. Support low cost health insurance packages which include maternity and well-child services.

PUBLIC EDUCATION

21. Promote public education of perinatal issues through the media, especially in the form of the Baby Your Baby campaign.

III. LONG TERM CARE

Few articles are as to the point as the following article: Myths and Realities, Why Most of What Everybody Knows About Long Term Care is Wrong. The article is provided in its entirety because it is an important opening portion of this section. It provides solid information to the reader, whether they be a professional or lay person.

MYTHS & REALITIES

Why Most of What Everybody Knows about Long-Term Care Is Wrong

Joshua M. Wiener and Katherine M. Harris

The place of long-term care on the national policy agenda has risen dramatically in recent years. Over the past year, *Newsweek* devoted a cover story to Alzheimer's disease, the *New York Times* ran a four-part story on long-term care, and Walter Cronkite narrated a special program on financing issues. Several key members of Congress in both houses have introduced legislation to overhaul the financing of long-term care. And long-term care is receiving equal billing with hospital and physician care in major reviews of health policy by the U.S. Bipartisan Commission for Comprehensive Health Care (the Pepper Commission), the White House Domestic Policy Council, and the Social Security Advisory Council.

As policymakers have hurriedly educated themselves about chronic disability, nursing homes, and home care, a body of conventional wisdom about long-term care has developed. Unfortunately, much of it is simply wrong. Of the many unfounded notions about long-term care currently in circulation, eight myths are especially prevalent.

Joshua M. Wiener is a senior fellow in the Economic Studies program at the Brookings Institution, where he has conducted extensive research on long-term care. He is the coauthor, with Alice Rivlin, of Caring for the Disabled Elderly: Who Will Pay? *(Brookings, 1988). Katherine M. Harris, who recently received a master's degree in economics from the University of Michigan, is a research assistant in the Economic Studies program at Brookings.*

MYTH 1: THE LONG-TERM CARE ISSUE AFFECTS ONLY THE ELDERLY

It is true that long-term care disproportionately concerns people aged 65 and over. But great numbers of people under 65 are also affected, both as the chronically disabled and as caregivers.

First, not all disabled people are old. At least a quarter of all adults who have trouble performing such basic personal tasks as eating, bathing, and dressing are under age 65. Broader definitions of disability that include such tasks as doing housework, shopping, and managing money increase the figure to 46 percent. Although disability is much more prevalent among the over-65 population, there are many more people under the age of 65 than over. So even a low disability rate among those under 65 produces a significant number of nonelderly disabled.

Despite their numbers, we know little about the characteristics and service needs of disabled people under age 65. We do know that they tend to make less use of paid services, such as home care and nursing home care, than do the elderly. But we don't know why.

Second, long-term care issues affect not only disabled Americans themselves, but also their families. When aging parents require care, it is usually their children who are called upon to provide it. Almost two-thirds of unpaid caregivers to the disabled elderly are under 65. And coping with a disabled elderly relative is becoming an increasingly common experience, largely because

people are living longer. In a national survey of voters of all ages, 47 percent said that someone in their family had already needed long-term care.

Because long-term care is an important family issue and not just a narrow interest of the elderly, public opinion polls reveal little evidence of tension between young and old about devoting resources to long-term care. Public opinion surveys, including those by the Daniel Yankelovich Group, consistently find that younger age groups support public spending for long-term care as much as, if not more than, older groups do. The consensus holds firm even when it comes to paying additional taxes.

Because long-term care is an issue involving the disabled of all ages and their relatives, equity would demand that the under-65 group be included in any future public program. Except to hold down costs, there is no good reason to limit initiatives to the elderly. Still, more research into how to serve the younger disabled population and how to support caregivers meaningfully is crucial to an effective and affordable program.

Myth 2: In the Good Old Days Families Took Care of Their Elderly Parents at Home, but Now Families Just Dump Disabled Relatives into Nursing Homes

The second myth laments the collapse of the extended family and the selfishness of the current generation. The reality is that disability rates increase rapidly with age. In the good old days, elderly relatives rarely lived long enough to develop chronic disabilities. The quadrupling of the number of elderly people in institutions between 1950 and 1980 was due not to families abandoning disabled relatives, but to falling death rates. More than two-thirds of the increase can be explained solely by the jumps in the absolute number of older Americans and the disproportionate growth in the population aged 75 and older, who have the greatest long-term care needs. One sign that families are not abandoning their disabled relatives is that nursing home use rates actually fell a little between 1977 and 1985.

In fact, most disabled elderly Americans continue to live in their communities, assisted by their relatives. In 1982, for instance, only about 21 percent of the disabled elderly were in nursing homes. Of those who were not in nursing homes, nearly 90 percent received unpaid support, mostly from wives, daughters, and daughters-in-law. American families devote enormous time and energy to the care of disabled relatives. The costs are emotional and physical as well as financial. One study estimated that 27 million unpaid, informal care visits were made each week in 1980 by family and friends.

Without unpaid family caregivers, public spending on long-term care would far exceed current levels. Predictably, policymakers are examining ways to increase unpaid care. They are unlikely to be successful, simply because families are already doing so much.

Myth 3: If Paid Home Care Is Provided, Families Will Stop Providing Unpaid Care

The fear that a government program of paid home care will reduce unpaid family care has paralyzed efforts to reform the long-term care delivery system. Policymakers do not want to pay for what is already provided at no cost to taxpayers.

Yet most studies suggest that when the disabled elderly receive paid home care, such as adult day care, skilled nursing services, personal care, and homemaker services, the unpaid care given by family members does not change significantly. According to William Weissert of the University of Michigan, of 53 findings in studies of the effect of paid home care on informal care, 41 were not statistically significant, 7 suggested a significant increase in unpaid support, only 4 suggested a significant decrease, and 1 was indeterminate.

A few of these studies are especially notable. An evaluation of a federally funded project, the Channeling Demonstration, found that providing a rich package of services caused only a small reduction in the percentage of disabled elderly receiving any informal care. It caused no significant change in visits per week from informal caregivers or in hours per day of care by the primary unpaid caregiver. A few types of help, principally homemaker services, had small but significant reductions, more by nonfamily than family caregivers. Another study, of California's Multipurpose Senior Services Pro

When aging parents require care, it is usually their children who are called upon to provide it. . . . American families devote enormous time and energy to the care of disabled relatives. The costs are emotional and physical as well as financial.

ject, found a small reduction in informal care: for people living with others, a 10 percent increase in paid care led to a 1.2 percent decrease in informal care. The effect was smaller for an elderly person living with a child or with a sibling nearby. Recent studies of the Minnesota Pre-Admission Screening–Alternative Care Grants Program and the Chicago Five Hospital Program found that informal caregivers did not reduce support following the introduction of paid home care services. Finally, an analysis of the National Long-Term Care Survey by Raymond Hanley and Joshua Wiener of Brookings found no significant substitution effects between paid and unpaid care.

To be sure, these findings measure mostly local, short-run experience rather than long-run responses to a national public or private insurance entitlement. Even so, they sharply contradict the expectation that informal care will collapse if paid home care is available. The implications are twofold. First, policymakers can probably expand paid home care without triggering an explosion of costs due to cutbacks of unpaid care. (Costs may still be high, but for other reasons.) Second, policymakers should not create a paid home care program with the expectation that it will dramatically reduce the burden on caregivers. Families and friends will continue to provide almost as much care as they would have without paid services. What paid home care can do is give caregivers a needed respite and allow them to arrange their hours and tasks more efficiently. Families will welcome the relief, but their burdens will remain great.

Myth 4: Very Few People Ever Use Nursing Homes, but Those Who Do Spend a Long Time There

Admission to a nursing home is, in fact, quite common. The lifetime risk at age 65 of spending some time in a nursing home is between 35 percent and 49 percent. But the stay may not be long-term: the lifetime risk at age 65 of spending more than one year in a nursing home is only about 22 percent.

Although many people justifiably fear the expense of a very long stay in a nursing home, relatively short stays are quite common. Estimates are that between 46 percent and 64 percent of nursing home stays are less than a year, and that between 26 percent and 45 percent are less than three months. The paradox is that, while long-stay patients are relatively few in number, they account for a huge proportion of nursing home patient-days. For example, according to Wiener and his former Brookings colleague Denise Spence, nursing home patients who stay longer than three years account for only about 20 percent of admissions but 70 percent of total patient-days.

Nonetheless, a nursing home stay, however brief, can be financially burdensome. A short stay in a nursing home will generate out-of-pocket costs that would be considered catastrophic if they were hospital or physician costs. A 75-day stay in a nursing home, for example, will cost more than the average hospital bill of $6,700 for treatment of pneumonia. For the 50 percent of short-stay patients who recover and return home, a relatively short nursing home stay can mean a lower income and fewer assets to pay for other emergencies.

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An accurate picture of the risk of needing long-term care is crucial in assessing trade-offs in the design of insurance policies for long-term care. Proposals, like those advanced by the Pepper Commission, that cover only short nursing home stays will completely cover many admissions but only a small percentage of total nursing home patient-days. Thus, public costs will be relatively small. Conversely, social insurance proposals, such as Senator George Mitchell's, that cover only very long stays will cover few patients but a large percentage of nursing home patient-days. Thus, public costs will be relatively large.

Myth 5: Home Care Can Reduce Long-Term Care Expenditure by Substituting for Expensive Nursing Home Care

Supporters of publicly funded home care often argue that these services will substitute for expensive nursing home care and thus actually reduce public long-term

Illustration by Robert Soule

care expenditures. But Peter Kemper, of the Agency for Health Care Policy and Research, and others have shown that in demonstration projects that offered expanded home care, total costs rose rather than declined, and nursing home use fell only slightly. For example, in the Channeling Demonstration, providing a wide range of home care services pushed up health and long-term care costs about 18 percent.

Older people's aversion to nursing homes explains this increase. Given a choice between nursing home care and nothing, many elderly people will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use.

Expected cost saving is, therefore, not a valid reason to expand home care. Various strategies, however, may be able to limit a home care program's incremental cost. Among them are targeting services to the most severely disabled, making reduction of hospital admissions a priority, exploiting technological "fixes" (such as automatic alarm systems), and aggressively monitoring use levels.

Still, there are reasons other than cost saving to support a paid home care program. A home care program would improve the quality of life by addressing an unmet need of the elderly and would provide the type of care that they overwhelmingly want.

Myth 6: Most Nursing Home Patients Pay Privately at Admission, but Are Welfare Recipients at Discharge

Probably the most widespread long-term care myth is that most people enter a nursing home as independent, private-pay patients, then, impoverished by the costs, turn to Medicaid, the federal-state health program for the poor, to pay for their care. Depleting one's income and assets down to Medicaid financial eligibility levels is known as "spending down." Given that the cost of a year in a nursing home often exceeds $30,000, it is hard to see how it could be otherwise. Nonetheless, recent studies consistently show that only a modest number of nursing home patients spend down to Medicaid. Conversely, many more patients are eligible for Medicaid at admission than previously thought.

While one simulation study of elderly Massachusetts residents suggests that 46 percent of those aged 75 and over living alone in the community would become eligible for Medicaid after only 13 weeks in a nursing home, no study of actual spend-down behavior has found an equivalent drain on resources. Many nursing home patients have relatively few resources to begin with. For example, a study using Michigan Medicaid claims data found that only a quarter of 1984 nursing home patients originally entered as private-pay patients. A Connecticut study, which linked multiple nurs-

ing home stays, found that 21 percent of private-pay nursing home patients spent down at some time during their stay and that 38 percent of Medicaid nursing home patients were private-pay at admission. Because they tend to have long lengths of stay, spend-down patients accounted for a somewhat higher percentage of Medicaid patient-days.

In a third study, using the National Nursing Home Survey, Spence and Wiener found that only about 10 percent of private-pay nursing home patients spend down to Medicaid during a single stay. Even with adjustments for multiple stays, Spence and Wiener estimate that the proportion of private-pay patients who spend down to Medicaid eligibility is in the range of 15–25 percent. By contrast, fully 35 percent of patients were eligible for Medicaid at admission. A substantial portion of the latter group probably would have had too much income to qualify for Medicaid had they continued to live in the community. However, the high cost of nursing home care made them immediately eligible for Medicaid upon entry to the nursing home.

There are several other explanations for the modest spend-down rate. First, as noted earlier, many nursing home stays are relatively short. Thus, at an average cost of $80 a day, the total cost of a three-month stay is $7,200, an amount that is sizable but manageable for many elderly people. By contrast, two-thirds of the patients who stay more than three years depend in part on Medicaid to help pay for their care. Even among this group, however, just 20 percent spend down; most are eligible for Medicaid at admission. Second, private-pay patients may avoid relying on welfare by selling their assets, including their houses, and by accepting money from relatives for their care. Although they may deplete their assets, they may never end up on Medicaid.

These research findings highlight the trade-offs between goals against which proposals for long-term care must be evaluated. One goal is to prevent the elderly from having to spend all their life savings on nursing home or extensive home care. Even if patients do not end up on Medicaid, nursing home care still imposes a substantial financial burden that can financially cripple them and their relatives. This goal is most important to the middle and upper-middle classes, who have significant assets to protect.

A second goal is to prevent older people from having to depend on welfare in the form of Medicaid. Public charity always carries some stigma, and efforts to reduce taxpayer costs are likely to perpetuate a two-class system with inferior status for Medicaid patients. Since most Medicaid patients in nursing homes are eligible at admission, focusing on the spend-down group ignores the large majority of Medicaid patients, who are presumably in the middle class or below, with few assets. Keeping this group off welfare deserves greater public policy attention than it has received to date.

Myth 7: Private Long-Term Care Insurance Can Solve the Problem of Long-Term Care Financing

Over the past few years the market for private long-term care insurance has grown rapidly, leading some policymakers to promote private insurance as the best way to finance protection against the catastrophic costs of long-term care at a time of government austerity. The reality is that only about 3 percent of the elderly currently have long-term care insurance. Even under optimistic assumptions about the future growth of the market, private insurance cannot do the whole job.

Studies done at Brookings, the Employee Benefit Research Institute, Families USA, and the Urban Institute all conclude that only a minority of the elderly can afford private long-term care insurance. Other studies have found that a higher percentage of the elderly can afford private insurance, but they have done so only by assuming that the policies were for limited coverage, by assuming that the elderly would use their assets as well as income to pay the premiums, or by excluding a large

By the year 2000 virtually all the parents of the baby boom generation will be elderly; thus baby boomers will have to face long-term care as a real-life, intensely personal problem, no longer just something to read about in Newsweek.

percentage of the elderly from the pool of people who might be interested in purchasing insurance.

Although there is room for substantial growth in private insurance, projections using the Brookings-ICF Long-Term Care Financing Model suggest that only limited segments of the population will be covered by the private sector. By 2018 insurance sold to those 65 and older may be affordable to 25–54 percent of the elderly, may finance 7–17 percent of total nursing home expenditures, and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by 1–16 percent.

Why will private insurance have a modest role in financing nursing home and home care? First, as already noted, private insurance is so expensive that most older people cannot afford it. The Health Insurance Association of America reports that the average annual premium for the 15 best-selling policies with inflation protection is $1,395 if purchased at age 65, rising to $4,199 if purchased at age 79.

Second, although coverage has been improved substantially over the past few years, financial protection is still limited. For example, benefits are rarely fully indexed for inflation, home care is highly restricted, and policies usually do not cover very long nursing home stays or home care episodes.

Third, insurers are worried because the long interval between initial purchase and ultimate use of nursing home and home care involves great uncertainty and financial risk. A policy bought by a woman at age 65 may not be used until she is 85, a full 20 years later. During those 20 years, unforeseen changes in disability or mortality rates, nursing home and home care utilization patterns, inflation in service costs, or the rate of return on financial reserves can dramatically transform a profitable policy into an unprofitable one. Such uncertainty will likely lead insurers to limit the number of policies they sell.

While private long-term care insurance can and should play a much larger role than it does now, it is not a panacea. Private insurance will not prevent public expenditure for long-term care from increasing substantially over the next 30 years, nor will it provide financial protection for the great majority of elderly. Expansions of public programs or very deep subsidies for the purchase of private insurance are needed to protect the elderly against the catastrophic costs of long-term care.

Myth 8: The United States Is the Only Developed Country besides South Africa That Fails to Provide Long-Term Care on a Social Insurance Basis

In an effort to shame Americans into action, advocates of reform sometimes charge that the long-term care financing system in the United States lags far behind those in the rest of the world. While it is true that South Africa and the United States are the only developed countries without national health insurance or a national health service, these programs principally cover acute care hospital and physician services rather than long-term care. There is, in fact, a great deal of diversity in the way countries provide long-term care.

In Germany and Switzerland, long-term care is delivered through a means-tested welfare program. The level of impoverishment required for eligibility, however, is usually less severe than it is in the United States. In France and Belgium, the social insurance program covers only the medical component of long-term care. The Netherlands and some provinces of Canada provide relatively comprehensive long-term care programs on a nonwelfare basis, although they require a fairly substantial level of cost sharing. Both countries, however, provide their universal entitlement in the context of a fixed appropriation rather than an open-ended financing program like Medicaid and Medicare. Japan has virtually no nursing homes or paid home care. Instead, nursing home patients tend to back up in acute care hospitals. (One financing characteristic that all these countries do share is the small role played by private long-term care insurance.)

While the U.S. system is by no means exemplary, it is not so different from those of other countries as to be beyond the pale. As we look for ways to reform the financing of long-term care in the United States, the experience of Canada offers some support to those who argue that long-term care can be provided on a universal, social insurance basis without expenditures skyrocketing.

Conclusion

As policymakers grope for solutions, it is essential that they have a realistic picture of the problems of long-term care. To a large extent, the conventional view of long-term care is at odds with the research literature. While some of the prevailing myths lend support to desirable initiatives, policy prescriptions based on inaccurate assumptions are likely to be ineffective and inefficient. Myths deflect attention from the real problems of providing and paying for care of the disabled.

Accurately defining the problems and realistically evaluating options is all the more critical because the issue of long-term care is likely to become increasingly prominent over the next 10 years. For one thing, the population aged 75 and older — the oldest old — will grow 25 percent by the year 2000. Even more important, virtually all the parents of the baby boom generation will be elderly; thus baby boomers will have to face long-term care as a real-life, intensely personal problem, no longer just something to read about in *Newsweek*. The combination of the elderly and their adult children will make long-term care a political issue that neither the president nor Congress can ignore.

III. LONG TERM CARE

One of the most significant issues facing Montanans in the next decade is financing the cost of long term health care. Based on the most recent research, it is estimated that at least one of every three Montanans over age 65 will eventually enter a nursing home, and more will need long term care at home. Increasing life expectancy and an exploding elderly population are combining to create a demand and financing crisis of staggering proportions. In order to meet this concern the Long Term Care Strategies Committee provided eight recommendations that move Montana forward in the long term care area.

RECOMMENDATION #1

Single Point of Entry Pilot Project

To direct the Governor's Office on Aging and the Department of Social and Rehabilitation Services to apply for Federal or private funds, to begin a pilot project that would provide a single point of entry for long term care services. It would seek to accomplish the following:

* A single point of access for all publicly funded long term care programs.
* An assessment of each applicant, including a individualized care plan.
* A smooth transition from private funds to eligibility for public programs.
* Assurance that all funding sources are maximized for each client.
* Educational opportunities for clients and families concerning options for long term care.

Improvements in the Community-Based Long-Term Care System

Long-term care provided to individuals in their homes or other non-institutional settings is a rapidly developing component of our health care system. Currently it is characterized to some degree by multiple and not fully coordinated funding sources, difficulty for consumers to access and understand and possibly a failure to serve those with greatest need.

Currently the most significant sources of funding for in-home serves are Medicaid, State General Fund money, Older Americans Act money, private contributions and local funds. It is currently difficult to determine the proper balance between funding for community-based care and nursing home care without a more coordinated system.

Interest has been expressed by the Committee in developing a model long-term care system that would provide:

1. a single point of access for all publicly-funded long-term care programs,

2. an assessment of each applicant, including an individualized care plan,

3. a smooth transition from private funds to eligibility for public programs,

4. assurance that all Federal funding sources are maximized for each client,

5. educational opportunities for clients and families concerning options for long-term care.

The Committee recommends that the Department of Social and Rehabilitation Services and the Governor's Office on Aging further develop this concept and seek funding through grants for a demonstration project to further test these concepts.

RECOMMENDATION #2

Expansion of Elderly Care Credits Act

To expand the present Elderly Care Credits Act to include the following:

* Decrease the age limit of the elderly person cared for from 70 to 65.
* Allow the credit for expenditures related to care of a person who is considered disabled under the Social Security Administration classification.
* Allow as creditable expenses those paid by the family member(s) to all health care facilities licensed by the Department of Health.
* Increase the income threshold for a married couple cared for from $15,000 to $30,000. This corrects an oversight in the original legislation.

RECOMMENDATION #3

Long Term Care Insurance Tax Deduction

To provide Montana citizens with a tax deduction for the purchase of Long Term Care insurance. The deduction would be 100% for premiums paid for by individuals. Only Long Term Care Insurance which meets standards set by the Insurance Commissioner's Office would be eligible for the deduction.

The second and third recommendations seek to encourage home health care and the purchase of long term care insurance. The explanation and the impact are provided in a Department of Revenue proposal.

STUDY ON INCOME TAX DEDUCTIBILITY OF LONG TERM CARE INSURANCE

ASSUMPTIONS:

1.) Persons between the ages of 50-79 who purchase a Long Term Care (LTC) plan can deduct the full cost of the premiums from gross income.

2.) The annual cost of an average LTC plan per age group are as follows (as surveyed from underwriters):

A.) 50-55	$363
B.) 55-64	$535
C.) 65-74	$1,413
D.) 75-79	$2,480

3.) Nursing home costs are used as a proxy for all Long Term Care costs since there is very little data available on home care.

A) The portion of nursing home payments that are being covered by Medicaid is 42% (according to the Health Insurance Association of America).

4.) Rates of Long Term Care Insurance (LTCI) policy use are assumed to be distributed evenly across income and age strata. This assumption is probably violated in reality because high income individuals are better able to afford LTCI than low income individuals.

5.) The average annual medicaid LTC cost to the State is $4,352.76 per patient (SRS, FY91)

ANNUAL FISCAL IMPACT OF LTCI DEDUCTIBILITY

DEDUCTION

	USE OF LTCI					
Age	1%	2%	4%	6%	8%	10%
A. 50-55	8,119.77	16,239.53	32,479.06	48,718.59	64,958.12	81,197.66
B. 55-64	19,582.61	39,165.21	78,330.42	117,495.63	156,660.84	195,826.05
C. 65-74	50,899.09	101,798.17	203,596.34	305,394.52	407,192.69	508,990.86
D. 75-79	36,742.44	73,484.88	146,969.76	220,454.64	293,939.52	367,424.40
Total Revenue Loss	$115,343.90	$230,687.79	$461,375.59	$692,063.38	$922,751.17	$1,153,438.97

MEDICAID SAVINGS

A. 50-55	0.00	0.00	0.00	0.00	0.00	0.00
B. 55-64	0.00	0.00	0.00	0.00	0.00	0.00
C. 65-74	22,669.19	45,338.39	90,676.77	136,015.16	181,353.55	226,691.93
D. 75-79	32,632.67	65,265.34	130,530.68	195,796.02	261,061.36	326,326.69
Total Savings	55,301.86	110,603.73	221,207.45	331,811.18	442,414.90	553,018.63
Fiscal Impact	(60,042.03)	(120,084.07)	(240,168.13)	(360,252.20)	(480,336.27)	(600,420.34)

COMMENTS:

This analysis of the cost effectiveness of allowing taxpayers to deduct LTCI premiums from their gross income results in several conclusions:

First, it should be obvious from the assumptions, that to obtain a more accurate estimate, an in-depth comprehensive study needs to be completed. However, there is a serious lack of data on the subject.

Second, from the analysis, it is apparent that it is not cost effective to allow the deduction for the specified age group (50-79). However, the deduction could be made more cost effective by allowing only taxpayers who are over the age of 70 (example) to deduct the LTCI premiums from gross income.

Third, this estimate of cost effectiveness is likely to be overstated because of the distribution of income among the consumers of LTC; low-income individuals will not be able to afford either the LTCI premiums or the nursing home charges and will consequently resort to Medicaid, while upper-income individuals will be able to afford the insurance premiums and some portion of nursing home charges. What this illustrates is that generally, the individuals who purchase LTCI (and take the deduction) would most likely not have used Medicaid anyway. The majority of the LTCI purchasers will most likely be individuals from upper-income groups. In summary, a proposal to deduct LTC premiums will result in a net revenue decrease (with a 48% savings/costs ratio).

NOTE: This analysis only looks at the fiscal impact on revenue and state Medicaid expenditures, it does not in any way consider the social desirability or benefit of LTCI.

NUMBER OF TAXPAYERS USING LTC DEDUCTION

Age Group	Population	**** 1.00%	**** 2.00%	NUMBER USING DEDUCTION 4.00%	**** 6.00%	**** 8.00%	10.00%
A. 50-55	38,500	385	770	1540	2310	3080	3850
B. 55-64	63,000	630	1260	2520	3780	5040	6300
C. 65-74	62,000	620	1240	2480	3720	4960	6200
D. 75-79	25,500	255	510	1020	1530	2040	2550
Total	189,000	1,890	3,780	7,560	11,340	15,120	18,900

AMOUNT OF REVENUE LOST TO STATE GOV'T DUE TO LTC TAX DEDUCTION

Age Group	Average Policy Cost	REVENUE LOST DUE TO DEDUCTION					
A. 50-55	$363.00	8,119.77	16,239.53	32,479.06	48,718.59	64,958.12	81,197.66
B. 55-64	$535.00	19,582.61	39,165.21	78,330.42	117,495.63	156,660.84	195,826.05
C. 65-74	$1,413.00	50,899.09	101,798.17	203,596.34	305,394.52	407,192.69	508,990.86
D. 75-79	$2,480.00	36,742.44	73,484.88	146,969.76	220,454.64	293,939.52	367,424.40
Total		$115,343.90	$230,687.79	$461,375.59	$692,063.38	$922,751.17	$1,153,438.97

INCOME TAX DEDUCTIBILITY OF LONG TERM CARE INSUR
DEC 1990

COST OF NURSING HOME CARE IN MONTANA

Total Average Daily Cost	56.39
(-)Average Daily Patient Cost	14.34
Average Daily Medicaid Cost	42.05
Average Annual Medicaid Cost	15,348.25
'X Montana Portion	0.28
State Annual Cost	4,352.76

RECOMMENDATION #4

Federal Waivers for Long Term Care Insurance

The Department of Social and Rehabilitation Services should be granted the authority to pursue waivers from the Federal government, that reduce the costs of Long Term Care, both to individuals and State Medicaid programs, by encouraging the use of Long Term Care Insurance.

The Long Term Care Committee considered two proposals to link long term care insurance and Medicaid. The committee preferred the second of the two approaches listed in the following section.

Efforts to reduce the costs of Long-Term care, both to individuals and to State Medicaid programs, by encouraging the use of Long-Term Care Insurance are currently underway in eight states. These pilot projects are being funded through grants by the Robert Woods Johnson Foundation.

These pilot projects generally take one of two approaches.

1) Offering purchasers protection of assets and/or income protection from Medicaid spend-down requirements based on the benefits they receive from the insurance policies they buy.

2) Subsidizing premiums or coinsurance and deductibles for long-term care insurance policies that meet State requirements.

The Committee focused primarily on those projects that follow the first model. Briefly, these programs would encourage individuals to plan for their long-term care needs by purchasing insurance protection in an amount commensurate with the amount of assets they wish to protect. Thus an individual with $50,000 of assets would buy $50,000 of insurance protection. If an individual exhausts insurance benefits they can apply for Medicaid, and each dollar that the insurance has paid out in accordance with state policy will be subtracted from the individuals remaining assets. In other words, the insurance payments for long-term care services will be considered as equivalent to spending of assets for the purpose of Medicaid eligibility.

Advantages of this model include 1) potential protection of elderly from costs of long-term care, 2) reduction in Medicaid expenditures by state and Federal Government, 3) assist state regulators in developing better standards and oversight, and 4) help insurers develop long-term care products.

Possible disadvantages include 1) increased cost to Medicaid programs if those who would never have "spent down" become Medicaid eligible, 2) encourage the use of insurance products that do not meet the need of consumers.

The Committee recommends that the Office on Aging, Insurance Commissioner, and Medicaid Division carefully monitor the progress of these pilot projects and report back to the Governor in one year on the advisability of pursuing a similar project in Montana.

RECOMMENDATION #5

Long Term Care Rider for State Employees Health Care Plan

The State employees health care plan should explore a long term rider as part of a cafeteria plan.

Because little information exists about Montanans interest in long term care insurance the committee recommended that a long term care insurance rider be offered to state employees. Obviously no one would be required to buy the plan but such an offering would provide knowledge about employee interest, the provisions employees would want in a policy and what kinds of education the state and insurance companies need to develop to market long term care insurance.

RECOMMENDATION #6

Expansion of the Medicaid Waiver Program

The department should have the ability to determine the best strategy for administering the Medicaid Waiver Program, including the ability to choose between the expansion of current waiver caseloads or the development of waiver services in new locations across the state.

In addition, an expansion of the Medicaid Waiver Program should be pursued.

The executive budget reflects the growing need to expand the Medicaid Waiver Program. The proposal is to continue this expansion through additional 50 slots. The committee supports this expansion because of the success of the program from past expansions.

Because not everyone who reads this report will understand the need an overview for an overview of the Medicaid waiver program is provided.

The Department of Social and Rehabilitation Services of the State of Montana offers Home and Community Services Program (also known as the Medicaid Waiver) to certain Medicaid eligible elderly and physically disabled individuals who require long term care. The program contains health care costs by providing home-based services as an alternative to institutional care. The Medicaid recipient is given a choice of receiving long term care services in the home setting or an institutional setting. The Home and Community

Services Program is case managed by teams consisting of a registered nurse and a medical social worker who are under contract with the Department of Social and Rehabilitation Services. The Home and Community Services Program is available to individuals who:

a) are elderly or physically disabled
b) are Medicaid eligible
c) require nursing facility level of care
d) reside in approved service areas
e) do not reside in a hospital or a long term care facility
f) have needs that can be met through the Home and Community Services Program at a cost not to exceed the maximum amount allowed
g) are under the direction and care of a physician who has prescribed long term care

The long term care programs offered through Medicaid have historically emphasized funding services provided in 24 hour institutional settings rather than home oriented community services. In 1983, the Medicaid program's institutional bias was softened somewhat by the passage of legislation creating the Medicaid waiver program. Under the Waiver, states may create a menu of community services that are not normally available under Medicaid, and provide these services to persons who would otherwise require placement in a Medicaid funded institution, such as a nursing home or Intermediate Care Facility for the Mentally Retarded. Unlike other Medicaid programs, all eligible applicants are not entitled to waiver services. Both the numbers of people served, and the amount of money to be expended, are limited through an agreement negotiated between each state and the federal government. The basic principle behind the agreement is simple: the state agrees that the average cost of care under the waiver will not exceed the average cost of care of the institutional alternative; in exchange the federal government participates in the cost of funding an array of community service options not traditionally offered through Medicaid.

Montana has participated in the Medicaid waiver program since its inception in 1983. Currently, the state has two waivers: one for elderly and physically disabled persons; one for persons with developmental disabilities. both of these programs have proven to be extremely effective at enabling people who desire to do so to remain in their homes and communities rather than be placed into institutional settings. Currently, the Department of Social and Rehabilitation Services (SRS) is authorized to provide Medicaid waiver services to about 500 elderly and physically disabled, and 300 developmentally disabled, persons. Unfortunately, both waivers currently have waiting lists.

RECOMMENDATION #7

Personal Care Pilot Project

To authorize the Department of Social and Rehabilitation Services to establish a pilot program for personal care homes in four sites. The sites would range in size from large facilities greater than 35 beds, to medium facilities of 16 to 35 beds, and to small facilities of 15 beds or less and would include freestanding and attached facilities.

BACKGROUND: Currently Montana operates a statewide program of Medicaid reimbursed personal care services through a contract with West Mont Home Management Corporation. Consistent with current federal requirements, West Mont provides personal care services to Medicaid eligible individuals in non-institutional settings, generally a person's own home. Licensed personal care facilities are included in the federal definition of institution and therefore specifically prohibited from receiving Medicaid reimbursement through the personal care option.

At the present time there are 22 licensed personal care facilities, with a total of 595 licensed beds, in the state. They range in size from 6 to 82 beds. The breakdown in size is as follows:

15 or less beds:	11
16 through 35 beds:	7
more than 35 beds:	4
Total	22

Recent legislation, OBRA 1990, appears to have expanded the possible locations in which personal care may be provided. Beginning in October of 1994, states may provide personal care services that are:

> "furnished in a home or other location; but not including such services as furnished to an in-patient of a hospital or nursing facility."

If this legislation is what appears to be, it opens the door to the possibility of Medicaid reimbursement in licensed personal care facilities. Obviously, since the option does not become available until 1994, any exploration of personal care facility Medicaid reimbursement in the near future would require the state to seek a waiver of some of the current personal care program regulations from the federal government. The pilot project outlined here is based on the assumption that Montana would seek a waiver of federal regulations in order to test the feasibility of Medicaid personal care reimbursement prior to October of 1994.

PILOT PROJECT: We believe that the impact of Medicaid funding for personal care facilities could be tested by providing Medicaid reimbursement to a subset of four facilities. The test facilities should be representative of the entire population: one greater than 35 beds, one from the 16 through 35 bed group, and two facilities from the 15 bed or less category. Reimbursement would be available to Medicaid eligible individuals who are pre-screened by the Department, or its representative, in order to ensure that they meet the level of care required for personal care facility services. The pilot project facilities would be selected based on the results of a statewide Request For Proposals (RFP) process. Among the issues to be examined by the pilot would be:

1. Reimbursement levels and procedures;
2. Pre-admission screening procedures;
3. medicaid utilization;
4. Consumer satisfaction; and
5. Impact on the demand for services.

Services could begin in fiscal year 1992, contingent on an appropriation by the legislature and the approval of a waiver of the regulations by the federal government. Preliminary pilot project results would then be available by the 1993 legislative session with the final results ready by the 1995 session. If a pilot is funded a steering committee made up of providers, ccnsumers, state agency personnel and, if possible, a representative from the legislature who is interested in long term care.

COST: The project would require an appropriation of funds to reimburse the test facilities. The amount necessary would be based on the facilities selected, the level of reimbursement provided, Medicaid utilization rates and the amount of patient contribution available. The average cost for basic personal care facility services in a recent phone survey was about $750 per month. A more detailed fiscal note will be developed should a decision be made to proceed with this proposal, but preliminary estimates indicate that it would require about $60,000 per year in general fund for each 100 beds involved in the pilot project.

RECOMMENDATION #8

Adequate Funding

To support adequate funding for all long term health care services and continued commitment to the leveraging of Federal funds through fees or other funding mechanisms.

This recommendation speaks for itself and recommends that the State of Montana pursue funding mechanisms available to address long term care.

IV. ACCESS AND AVAILABILITY TO HEALTH CARE

For many areas of Montana, access and availability to health care has become of paramount importance. Dr. Van Kirke Nelson, Chairman of the Health Care Services Availability Advisory Council, explains the dilemmas in the pages that follow.

MONTANA

RURAL HEALTH ACCESS IN THE DECADE OF THE 90'S

As we enter the decade of the 90's Montana faces:

A. A declining population with 36 of 56 counties having lost population in aggregate of 20%; (see table 1)

B. A declining birth rate, approximating 20%;

C. An aging population;

D. A loss of physicians in rural areas, hospitals and provider services with resultant negative economic impact on those rural communities. Eighteen counties presently function without any physician and twenty-two counties without physicians who deliver babies. (see table 2). The impact of physician and hospital loss on a rural community must be obvious.

   a. Lack of access to emergent care;
   b. Lack of obstetrical/pediatric care;
   c. Lack of access to care to an aging population, many with fixed incomes, with the increased necessity of traveling distances with the complication of disabilities, hearing, sight loss, need of a traveling companion and resultant increased costs for that transportation, food and lodging.
   d. loss of revenue base to a community.

Pregnancy and birth are fundamental components of rural life. In the past decade there has been a significant erosion in our ability to provide adequate perinatal care to the rural women and infants in Montana. This fact is so significant as demonstrated in statistics which clearly indicate we have one of the lowest neonatal death rates,(first thirty days of life - 4.8 per thousand) in the nation. Yet, when you consider our infant mortality in the first year of life, we are 32nd in the nation. (see table 3) If you deliver outside of the county of your residence in Montana, your infant in the first year of life has twice the chance of being included in that statistic. (Reed - McBroom, University of Montana)

There have always been barriers to care in rural Montana -- the principles of which have been isolation, the deficiency of medical personnel and technology. In the decade of the 70's the National Health Service Corps Scholarship Program provided, at its peak, 3,300 providers of medical services, primarily primary care physicians, these physicians assigned to rural areas. In 1981, Congress ended the scholarship program and there are but a handful of physicians yet remaining under that program. In the past decade there continues a mass exodus of physicians from rural areas and more who have given up obstetrics.

Certainly declining county population has an influence on physician loss. In addition, no single factor may be more important to this loss or exodus than malpractice insurance related problems. Recent statistics, provided by the Montana Academy of Family Practice and the Montana Medical

Association clearly illustrate this loss of physician providers. (See table 4).

The high cost of obstetrical liability insurance, combined with low reimbursement levels by many public and private insurers, along with the high volume of uncompensated care, can make the practice of obstetrics unaffordable to the physicians in rural areas. The 1989 AMA Socioeconomic Monitoring System Corps Survey reports that the national average percentage obstetricians pay of their income for professional liability insurance is 20%, whereas for all physicians the average is 6.9%. In Montana, the percentage for an obstetrician is approximately 33% ($39,000) and for a rural family practitioner doing obstetrics about 23% ($20,880).

In sparsely populated areas, those physicians available depend upon one another for back up and consultation. When a physician leaves or terminates a service, an additional pressure is placed on the remaining physician or physicians, frequently triggering a chain reaction or domino effect with further physician loss. Because of the lack of providers the obstetrical unit in the local hospital closes with the inevitable consequence of a new barrier to women who are forced to turn to other towns and other providers for perinatal services, an added expense to the economically disadvantaged rural family. The course is then set for inadequate perinatal care and pre-term delivery with its resultant low birth weight infants and as we have seen, an increase in the infant mortality rate. Not only is this a tragedy to those who suffer in the loss but it is expensive. The statistics from SRS indicate that the cost to the State of Montana in 1988 for care of 83 low birth weight infants was $2,696,461.00, or $32,487.48 per infant, one half of actual cost, the balance uncompensated care by the hospital. Considerable data available indicates that for every dollar spent in early prenatal care, $3-4 will be saved at the other end.

The mandate of the 90's will be for us to provide "the fundamental right" or "entitlement" that guarantees every woman and infant easy and ready access to a physician provider. Clear contributing factors to the decline of accessibility to care, prior to 1989 and OBRA-89, have been the inability of SRS to obtain adequate funding from the legislature and an inability to lesson restriction on eligibility.

With the inadequacy of compensation by Medicaid came a termination of provision of obstetrical services or a refusal to participate in the Medicaid program, which assumes more importance as the number of women covered by Medicaid is expanded and as the number of physicians who practice obstetrics declines. The following demonstrates the fragility, even in urban areas, where one group of providers provide the majority of care to Medicaid recipients through easier access. Their cessation of services would provide immediate impact to access. (See table 5).

Since the last legislature met, Congress, in a major step, passed OBRA-89 mandating that all states increase eligibility for Medicaid to 133% of the federal poverty level and further guarantee payment for services that is commensurate with guaranteeing access to care in the locale in which the recipient lives.

A survey conducted through the auspices of the Montana Medical Association and SRS indicates what the level of compensation should be to increase access to care. Increased physician payment for services to the Medicaid recipient does not necessarily guarantee access to care in a rural area where the number of obstetrical patients, including Medicaid recipients, does not generate enough income to pay for the high cost of liability insurance premiums.

Further, as an increasing number of obstetrical consumers become Medicaid eligible, the financial impact to hospital obstetrical services becomes more significant. Charges stay reasonably stable so long as the length of stay decreases. The length of stay can only be "ratcheted" down so much. Hospitals are reimbursed for obstetrical services for the Medicaid recipients based on DRG's and not by charges incurred. When the average length of stay can no longer be lowered costs will rise. (See table 6). SRS, through appropriate legislative funding, must keep hospital obstetrical units financially viable. Historically, rural family physicians have provided a full spectrum of care to all age groups in the community. In many instances, the termination of obstetrical services and the subsequent loss of pediatric and young family care, have led to physician loss in the community because of inadequate income. This Council feels that for true physician viability in rural areas, a physician must be "financially able" to provide all services.

Mandatory assignment by Montana physicians for Medicare recipients has been urged by senior groups in urban areas. Yet the largest seniors group, the AARP (American Association of Retired Persons) strongly opposes mandatory assignment in Montana because of the delicate balance of available care in rural Montana and the possibility of further loss of providers if those providers are unable to financially remain viable. Presently, only 22 percent of Montana physicians are "participating physicians" and accept assignment on all patients. Yet 70 percent of all physicians bills for elderly care have been submitted, "accepting assignment". The Montana Medical Association through their MontShare Program" have issued nearly 5000 "gold cards" to Montana Seniors which, upon presentation to their participating physician, qualifies them for assignment "with no questions asked".

Through the five hearings of the council, it has been very apparent that information and data collection is difficult and the need for data gathering and information that is <u>current</u> is of extreme importance in plotting health needs of the state of Montana. It is imperative that a comprehensive information system be developed that can identify where scarce resources are most critically needed. More importantly, measure the effect of these efforts on the well-being of the people of this state.

The "MIAMI PROJECT" funded in the last state legislature and with close cooperation between DHES and SRS has in seven project areas already demonstrated a decrease in low birth weight infants and a marked decrease in costs for medical care to those infants to the State of Montana. Nine additional project sites are anticipated and the continuity and legislative funding of the project is felt to be of the utmost importance to the public welfare of Montana.

KIDS COUNT the joint project of SRS and DHES demonstrates keen insight into Montana's needs in health care for its young people as well as addressing many facets of medical care. Its acceptance and support by the legislature seems almost mandatory.

Governor Stephen's program for insurance for the uninsured through his "Health Care for Montanans" likewise is a giant step forward in access to health care for Montanans and is presently being evaluated by other councils.

Finally, the council recognizes the lack of nonphysician health care providers in Montana. The council feels very strongly that the Montana State University System should provide for the education of the necessary nursing personnel, laboratory technicians, respiratory and occupational therapists, radiology technicians and many other disciplines of necessary providers that make access to health care for Montanans a reality.

Our council, the Health Care Services Availability Advisory Council wishes to thank all of those who have taken their time to address these important issues. As Chairman, I would like to thank an excellent, hard working council.

Van Kirke Nelson, M.D., Chairman

How the States Rate Health-Wise

The second national health study, financed by Northwestern National Life Insurance Co., shows that America's healthiest people (as of Aug. 7, 1990) live in Utah, Minnesota, New Hampshire and Hawaii.

The unhealthiest reside in Alaska, West Virginia, Mississippi and Nevada.

The full state-by-state report, based on five main components—lifestyle, access to health care, disability, disease and mortality—appears below. There were a number of ties in the rankings.

Ma kenzie/FPG

Healthy couple enjoys the outdoors in Utah

		Subcategory rankings				
Rank	State	Lifestyle	Access	Disability	Disease	Mortality
1	Utah	1	20	6	6	5
1	Minnesota	6	6	28	3	3
3	New Hampshire	6	2	28	12	8
4	Hawaii	5	5	1	19	2
5	Nebraska	4	14	41	5	9
5	Connecticut	16	1	21	25	9
7	Massachusetts	17	3	28	30	6
7	Wisconsin	9	16	28	11	6
7	Iowa	12	16	45	10	3
10	Kansas	17	7	28	9	9
10	Colorado	12	22	6	4	13
12	Vermont	12	14	28	16	14
12	North Dakota	2	44	28	2	1
12	Maine	11	19	41	19	14
15	Virginia	20	9	12	16	21
16	New Jersey	19	4	21	41	19
17	Rhode Island	23	10	41	37	9
18	Montana	3	41	12	7	16
19	Ohio	26	20	28	16	20
20	Pennsylvania	22	11	45	40	21
20	Indiana	29	23	28	14	29
22	California	31	12	4	39	21
23	Michigan	38	24	21	14	34
24	South Dakota	9	43	28	7	18
24	Maryland	34	7	12	43	30
26	Oklahoma	23	25	21	28	37
26	Wyoming	20	42	9	1	30
26	Delaware	29	16	21	42	40
26	Missouri	26	28	45	37	27
30	Washington	12	25	11	49	16
30	Texas	31	34	5	24	21
32	North Carolina	38	25	21	30	37
33	Idaho	8	46	12	13	34
34	Georgia	38	29	12	30	48
34	Tennessee	45	31	28	30	37
34	New York	48	12	12	45	40
34	Illinois	41	36	12	26	30
38	Kentucky	43	38	28	28	40
39	Alabama	43	39	41	19	45
39	Arkansas	41	40	45	30	34
39	Arizona	34	32	6	47	21
39	South Carolina	45	33	12	36	50
43	Oregon	26	36	21	50	21
44	Florida	50	29	45	45	27
45	New Mexico	31	50	2	19	30
45	Louisiana	47	45	12	27	44
47	Nevada	49	34	9	48	40
47	Mississippi	34	47	28	19	49
49	West Virginia	34	49	45	30	45
50	Alaska	23	48	2	44	45

IV. ACCESS AND AVAILABILITY TO HEALTH CARE - WAMI/WICHE RURAL PHYSICIANS PROGRAM

RECOMMENDATION #1

To require WAMI and WICHE medical students to pay back eight percent of the yearly support fee. Said funds to be held in a special trust account in the state treasury, the funds to be administered by the university system, the funds, with interest, to be utilized for a "educational relief fund" to those WAMI-WICHE students who return to Montana to practice in rural areas defined as communities in which the hospital is 50 beds or less or where no hospital is present - see addendum #1.

There are currently 48 slots open for doctors in Montana. Most of the openings come from rural areas. Up this point in time little has been done to enhance rural communities abilities to recruit doctors. Recommendation #1 and #2 offer a plan that would give rural areas a hand up in the recruiting process.

I. PURPOSE

A. To assure that students who benefit from the WAMI and WICHE programs pay an equitable share of the costs of these programs.

B. To finance debt relief program for physicians who practice in medically underserved areas of rural Montana.

II. COMPONENTS OF THE PLAN

A. Student contributions to WAMI and WICHE medical program support fees.

1. Montana students who matriculate in WICHE and WAMI medical programs will pay a mandatory annual fee in addition to their regular tuition, which will comprise part of the WICHE and WAMI support fee paid by the State of Montana.

a. After a phase-in period the amount of the annual additional fee will equal 8% of the annual support fee for that educational program as negotiated by WICHE. WAMI students will pay 8% of the annual WICHE support fee for medicine, thus keeping the student contribution the same for alls students enrolled in medicine.

b. The additional fee will be assessed by the Board of Regents and deposited in an earmarked account in the state treasury.

c. The phase-in period will begin in 1992 and apply to students who enter in 1992 and subsequently. For 1992 the annual student fee would be 8% of the annual support fee.

2. The amount budgeted to the University System for WAMI and WICHE support fees from the General Fund will be decreased by an amount equivalent to the total additional fees collected from students.

B. Creation of a trust fund to provide debt relief for physicians (and other health care providers) who practice in medically underserved areas of rural Montana. This is an integral part of the proposed legislation and cannot be dissociated from the above.

1. The fund shall be called the Rural Physician (or Rural Health Care Provider) Recruitment Incentive Fund (RPRIF) and be deposited in a dedicated expendable trust account in the state treasury.
2. An amount of money equivalent to the total annual fees of students to WAMI and WICHE support fees shall be credited annually to the RPRIF. All interest earned shall accrue to the trust fund and be dedicated to the program.

3. The fund shall be administered by the University System with a board of advisors knowledgeable and experienced in the management of rural health care problems and resources.

C. Use of the Rural Physician Recruitment Incentive Fund

1. The funds will be used to pay educational debts of physicians (or other providers) who practice in medically underserved areas of Montana which can demonstrate need for assistance in physician recruitment.

2. The University System, with direction from the above advisory board, will determine the areas of the state in which practice of medicine would qualify a physician for debt relief. In general, the underserved community will have to provide the evidence that a physician shortage exists and/or that the community has been unsuccessful in recruiting physicians by other mechanisms. (At the present time the target areas would be communities having hospitals with fewer than 50 beds, especially in north-central and eastern Montana.)

3. Physicians would apply for debt relief by demonstrating indebtedness through loans administered by the medical school which they attended and by contracting with the state that they would practice in underserved areas (as defined above) for periods up to 4 years. To receive the debt relief money the physicians would sign an annual contract which would specify that they would have to repay the money on a prorate basis should they leave the state before the end of the contract year. The maximum benefit would be the lesser of the total educational debt of the eligible physician or $30,000. It would be paid out on an accelerating schedule as follows:

   a. Year 1 - $ 4,000
   b. Year 2 - $ 6,000
   c. Year 3 - $ 8,000
   d. Year 4 - $12,000.

4. The amount contractually committed in any given year could not exceed the annual amount credited to the fund.

5. Funds not used during a given year would be invested towards the goal of establishing an endowment that would make the program self funding and that would make it possible to decrease student fees in the future.

6. It is anticipated that students will be able to come up with the extra money needed to pay their contribution of the support fee from the usual sources, i.e. personal resources, family, student loans. However, if necessary, some portion of the RPRIF could be set aside as the basis of a supplemental guaranteed student loan program.

HEALTH PROFESSIONAL EDUCATION AND RURAL HEALTH CARE IN MONTANA
LOAN INCENTIVE AMOUNTS

YEAR	NUMBER OF PHYSICIANS & AMOUNTS	STUDENT FEE COLLECTIONS	LOAN AMOUNT	BALANCE
1992	7 @ 4,000	45,600	28,000	17,600
1993	7 @ 6,000 7 @ 4,000	91,200	70,000	38,800
1994	7 @ 8,000 7 @ 6,000 7 @ 4,000	143,625	126,000	56,425
1995	7 @ 12,000 7 @ 8,000 7 @ 6,000 7 @ 4,000	191,500	210,000	37,925
1996	7 @ 12,000 7 @ 8,000 7 @ 6,000 7 @ 4,000	201,100	210,000	29,025
1997	7 @ 12,000 7 @ 8,000 7 @ 6,000 7 @ 4,000	201,100	210,000	20,125
1998	7 @ 12,000 7 @ 8,000 7 @ 6,000 7 @ 4,000	211,200	210,000	21,325
1999	7 @ 12,000 7 @ 8,000 7 @ 6,000 7 @ 4,000	211,200	210,000	22,525

COST TO WICHE/WAMI MEDICAL STUDENTS

YEAR	SUPPORT FEE*	NUMBER OF STUDENTS	COST PER STUDENT**
1992	$22,800	25 Students	$1,824
1993	$22,800	50 Students	$1,824
1994	$23,940	75 Students	$1,915
1995	$23,940	100 Students	$1,915
1996	$25,137	100 Students	$2,011
1997	$25,137	100 Students	$2,011
1998	$26,394	100 Students	$2,112
1999	$26,394	100 Students	$2,112

* Assuming a 5% increase every two years. 1992 and 1993 Support Fees are those currently known.

**Assuming 8% of the Support Fee.

IV. ACCESS AND AVAILABILITY TO HEALTH CARE - RURAL PHYSICIANS TAX CREDITS

RECOMMENDATION #2

A Montana state tax subsidy of $5,000 a year, not to exceed three years for new physicians in rural areas, defined as community in which the hospital is 50 beds or less or where no hospital is present.

This recommendation couples with the WICHE/WAMI program to recruit physicians into rural areas. The Council strongly believed that both recruiting tools were needed in order to compete with other states recruiting programs. It would apply to seven new physicians each year.

IV. ACCESS AND AVAILABILITY TO HEALTH CARE - INCREASE COMPENSATION FOR OBSTETRICAL AND PEDIATRIC CARE

RECOMMENDATION #3

Increase Medicaid compensation for obstetrical and pediatric services. The council endorses the OBRA 89 mandate to states and concurs with SRS and DHES in "Kids Count" with enactment of legislation to follow those recommendations.

The number of doctors delivering babies in Montana continues to decline. A precipitous drop began to occur in 1986. Between 1986 and 1988 the number of doctors delivering babies declined 29%. The decline continues today with only 23% of the doctors delivering babies. The delivery rate for Medicaid patients is even more onerous. In fact, at least 18 counties have no OB care with 19 in danger of losing this service. A slide toward one half of the state without OB care does not bode well for new babies and their mortality rate.

In 1990, 26% of all babies born in the state will be covered by medicaid. The Medicaid program presently pays physicians at 50% of the insurance rate for delivering children. Access to OB health care is falling for all mothers and much more quickly for Medicaid mothers. A raise in the rate to obstetrical physicians and general practitioners would boost well babies health care. A 90% rate from the Medicaid program is what is needed to abate the trend and is now required by the federal government. For too long Montana has asked doctors to absorb the cost of rising malpractice insurance and low reimbursement rates of 50% to deliver healthy babies. The time is now to address the issue through the Medicaid reimbursement rates. Our children and our future depend on it.

IV. ACCESS AND AVAILABILITY TO HEALTH CARE - POOLING FUNDS FOR LOAN FORGIVENESS

RECOMMENDATION #4

The state of Montana should establish a pool of funds to provide loan forgiveness to persons who practice in rural settings within health care professions.

Many committee members felt that the rural recruitment program for physicians should be expanded to other health care professions. Clearly similar recruiting problems exist for nurses, physical therapists, physician assistants, etc. White the proposal for doctors involves the use of tuition money this recommendation asks that the State of Montana provide a pool of money for loan forgiveness to those who practice in rural areas. Similar programs were successful for many years within the Indian Health Service and through other federal agencies.

IV. POLICY AND PLANNING ISSUES

Many of the policy and planning recommendations were put forth by the committees were straight forward and require less explanation. They range from conceptional ideas to specific calls for action that the Montana Legislature could work toward. Those recommendations were as follows:

RECOMMENDATION #1

Establishment of a Health Care Planning Trust Fund

The establishment of a special trust fund within the Montana Department of Health and Environmental Sciences, administered by a governor appointed board, consisting of a representative of the Montana Hospital Association, the Montana Medical Association, a representative of SRS, a rural physician, two rural consumers and a rural hospital administrator. That a fee, $25.00, be assessed and paid with the filing of each birth certificate with the bureau of vital statistics, Department of Health and Environmental Sciences, by the attendant listed on the birth certificate. The effective date of passage will be the same as date of increased payment for medicaid obstetrical and pediatric services. The bill would sunset in five years. Based on twelve thousand deliveries yearly, the average annual income would be $300,000, or $1,500,000 for five years. The funds to be expended, $100,000 in the first year for updating data gathering capability of the bureau of vital statistics, DHES, in reference to Montana health care, sharing that ability with SRS, the Montana Medical Association and other organizations requiring data on health care. Each subsequent year, for four years, $50,000 per year. (See addendum 2 - proposal for Montana state center for health statistics).

The balance of the funds would be for a direct subsidy of liability insurance (the obstetrical component) for new physicians in rural areas for a maximum of three years and to assist communities in physician recruitment through subsidy of matching funds with criteria to be established by the board for that match. That the statute sunset in five years, the board to continue administration of grants from the interest on the corpus of the trust. Further, that a one half hour documentary video tape on the benefits of rural practice be produced and disseminated advocating the advantages of a rural Montana practice and the potential subsidies offered by the State of Montana.

RECOMMENDATION #2

Opposition to Mandatory Assignment

Strong concurrence with the AARP, the American Association of Retired Persons, opposing mandatory assignment, which if enacted

by the Montana Legislature, would further erode physician availability in rural Montana and access to an aging population.

RECOMMENDATION #3

Tort reform for health care providers.

Strengthening tort reform through 1. modification of "Good Samaritan Law" to protect physicians, hospital and health care providers when rendering emergency care. 2. limitation of damage provisions, a fact-based discretionary "ceiling" on noneconomic damages. 3. mandatory periodic payment - see addendum 3.

Three provisions for tort reform are attached for the reader to examine.

LIMITATION OF DAMAGE PROVISIONS

FACT-BASED DISCRETINARY "CEILING" ON NON-ECONOMIC DAMAGES

NEW SECTION. Section 1. Separate Statement of Non-Economic Damages. In any action for damages for injury, whether based on tort, contract, or otherwise, the amount of non-economic damages recovered by any person or persons arising out of the same breach of an obligation shall be separately stated by the trier of fact.

NEW SECTION. Section 2. Non-Economic Damages Subject To Review And Alteration As To Whether Reasonably Proportional To Severity Of Injury Or Excessive Or Inadequate. (a) Upon application of a party to an action, an award of non-economic damages by a jury shall be reviewed by the judge, who shall consider the factors set out in [Section 2(b)], and acting with caution and discretion, the judge may thereafter decrease the award of non-economic damages, giving written findings of fact and conclusions of law for the basis for any change in the award.

(b) Unless there is clear and convincing evidence that the interest of justice would not be served thereby, an award of non-economic damages under this chapter shall be reasonably proportional to the severity of the injury and shall not be excessive.

NEW SECTION. Section 3. Change After Comparative Negligence Reduction. Any reduction by the judge in the amount of an award for non-economic damages permitted by this section shall be made only after reducing the amount of the jury award for comparative negligence, if any.

NEW SECTION. Section 4. Definitions. As used in this chapter, the term "non-economic damages" means damages arising from pain, suffering, inconvenience, grief, physical impairment, disfigurement, mental suffering or anguish, emotional distress, pain or suffering, loss of society, companionship or consortium, fear of loss, illness, or injury, injury to reputation, humiliation, and any other subjectively determined non-monetary or non-pecuniary damages.

NEW SECTION. Section 5. Applicability. This chapter shall be applicable to all causes of actions arising after the effective date of this chapter.

LIMITATION OF DAMAGE PROVISIONS

MODIFIED "GOOD SAMARITAN" LAW

27-1-714. Limits on liability for emergency care rendered at scene of accident or emergency. (1) Any person licensed as a physician and surgeon, or a hospital or long-term care facility under the laws of the state of Montana, or their agents or employees, any volunteer firefighter or officer of any nonprofit volunteer fire company, or any other person who in good faith renders emergency care or assistance ~~without compensation except as provided in subsection (2)~~ at the scene of an emergency or accident is not liable for any civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such emergency care or assistance.

~~(2) Subsection (1) includes a person properly trained under the laws of this state who operates an ambulance to and from the scene of an emergency or renders emergency medical treatment on a volunteer basis so long as the total reimbursement received for such volunteer services does not exceed 25% of his gross annual income or $3,000 a calendar year, whichever is greater.~~ The "scene of an emergency or accident" as used in this section shall include, but not be limited to, hospitals, long-term care facilities, and the offices and homes of physicians if the hospital, long-term care facility, or physician seeking the benefit of this section had no pre-existing patient relationship requiring care for the injured party at the time of the rendering of the care in question.

~~(3) If a nonprofit subscription fire company refuses to fight a fire on nonsubscriber property, such refusal does not constitute gross negligence or a willful or wanton act or omission.~~

ILLUSTRATIVE PROVISION MANDATING PERIODIC PAYMENT OF FUTURE DAMAGES

Sections 25-9-401 Through 25-9-406, MCA

"25-9-403. Request for periodic payment of future damages. (1) A party to an action for personal injury, property damage, or wrongful death in which $ 100,000 or more of future damages is awarded may, prior to entry of judgment, request the court to enter a judgment ordering future damages to be paid in whole or in part by periodic payments rather than by a lump-sum payment. Upon such request, the court may must enter an order for periodic payment of future damages ~~if the court finds that such payment is in the best interests of the claimant~~. The total dollar amount of the ordered periodic payments must equal the total dollar amount of future damages without a reduction to present value."

RECOMMENDATION #4

Strengthening the Medical Practice Act.

The council supports the strengthening of the medical practice act by the Board of Medical Examiners and further, supports the addition of a "paralegal" to the board of medical examiners, the cost through increase in medical licensure fee.

RECOMMENDATION #5

Educational opportunities for health care professionals.

That the Montana University system provide adequate educational opportunity to meet the needs of Montana's health care industry.

RECOMMENDATION #6

Charity Care.

The state of Montana does not need to develop a program for charity care or define the hospital's obligation to provide charity care.

RECOMMENDATION #7

Full funding of Montana's medical programs.

State government should fully fund and structure programs that the state is responsible for, ie. Medicaid, State Medical and Workers' Compensation. The eligibility criteria should be maintained at current levels. The state's programs should not shift the population of insured persons under Medicaid to increase the uninsured population.

RECOMMENDATION #8

Full funding for health care training programs.

The state of Montana should fully fund health care training programs through the university system to meet employment needs of health care providers.

RECOMMENDATION #9

State revenues for health care.

The state of Montana should develop policies for revenue provision that fully fund all state obligations. Revenues for health care needs should be borne by the general population and not through selected fees.

RECOMMENDATION #10

Need for rebasing.

That DRG trauma and outlier policy, mental health, rehabilitation, neonatal and cardiovascular care be rebased for the upcoming biennium. Appropriate funding should be provided by the state to meet the needs of rebasing.

RECOMMENDATION #11

Creation of an Office of Rural Health.

The state of Montana should create an Office of Rural Health to serve as the focal point for rural health care issues.

RECOMMENDATION #12

Creation of a Montana Health Care Policy and planning process.

The state of Montana should develop a health care policy to address access and delivery of services. The policy should be that health care decisions are based on health care planning not on a budgetary process. The Governor should appoint a committee to develop such a plan and provide their findings to the 1993 Legislature. A health care conference should be convened after the 1991 legislative session to further address health care concerns and appoint such a council.

RECOMMENDATION #13

Adequate funding for long term care services.

To support adequate funding for all long term health care services and continued commitment to the leveraging of Federal funds through fees or other funding mechanisms.

ADDENDUM

Revenue Sources

Since revenue considerations often enter into health care discussions the information that follows points out the options available.

States are using a variety of funding mechanisms to finance health care for low-income persons, including the following:

DIRECT APPROPRIATION OF STATE FUNDS. As described earlier, most states appropriate funds directly to their uncompensated care program or in conjunction with another program, such as a state-sponsored teaching hospital.

GENERAL SALES TAX, PROPERTY TAXES, OR SPECIAL PURPOSE EXCISE TAXES. New Mexico allows counties to assess an additional sales tax to fund indigent hospital care. Indiana created a state fund in 1986 to pay for hospital care for the indigent, financed by property tax levies. Ohio earmarks funds from motor vehicle license fees to finance the care of medically indigent accident victims. Indiana and Utah earmarked cigarette taxes to expand Medicaid coverage for uninsured young children and pregnant women. As mentioned previously, Minnesota earmarked new cigarette tax proceeds to fund its Children's Health Plan in 1987. In 1989, the Legislature transferred the cigarette tax proceeds to the state general fund and now appropriates general fund revenues to the insurance program. California voters approved a ballot initiative in 1988 that increases cigarette taxes to help fund uncompensated health care costs, among other purposes. The Legislature will determine how the revenues will be used.

EARMARKING STATE LOTTERY FUNDS OR GAMBLING REVENUES. Pennsylvania earmarks lottery proceeds for pharmaceutical assistance for the elderly. New Jersey appropriates funds from casino gambling taxes for health care for elderly and disabled persons. A Montana law provides that money seized for violation of gambling laws will supplement property tax assessments for care of medically indigent persons.

TAX-DEDUCTIBLE TRUST FUND. The concept of a health care trust fund is similar to the children's trust funds that exist in a number of states to help protect abused and neglected children. Another trust fund approach is illustrated in Georgia, where proceeds from the sale of a hospital by a political subdivision or hospital authority must be placed in a trust fund to provide health care for the indigent.

TAX ON HOSPITALS OR OTHER HEALTH CARE PROVIDERS. Florida assesses hospitals 1.5 percent of annual net operating revenues for the state's Public Medical Assistance Trust Fund. Initially, funds

were used to expand Medicaid coverage for low-income persons, but this effort was not as costly as expected and a large surplus collected. In 1987, the Legislature directed that some of the funds be used to reimburse health care providers who offer substantial charity care. new York, Ohio, South Carolina, Virginia, and Wisconsin also tax hospitals to help cover some health care costs for low-income persons. Most of the money is distributed to hospitals with high volumes of uncompensated care. Maine taxes hospitals to subsidize its insurance risk pool and to pay the administrative costs of the state's Health Care Fiance Commission. West Virginia taxed hospitals in 1985 and 1986 to supplement general funds for the state's Medicaid match.

The assessment formulas, purposes, and distribution mechanisms vary among states that tax hospitals. Legislators who are interested in this funding source confront several policy issues, including the following: how much hospitals should pay and how the money will be collected; whether assessment formulas should take into account gross revenues, uncompensated costs, amount of care provided to Medicare and Medicaid patients, and amount of taxes paid; for what purposes the money will be used; and how funds will be distributed.

Supporters of hospital assessments see them as an explicit form of cost shifting that can spread uncompensated care costs more equally among hospitals if the revenues are allocated to those with the highest burdens. Others argue that taxing hospitals and their patients is unfair, especially when the funds are used to pay for non-hospital care.

A few states have considered taxing other health care providers. An unsuccessful 1985 Washington proposal would have assessed a 1 percent tax on the gross income of "persons engaged in practicing medicine."

LICENSE FEES. Effective July 1, 1989, Tennessee hospitals pay an annual license fee to the state's Indigent Health Care Trust Fund. Fees are based on the amount of indigent care, charity care, and bad debt provided, as defined by the state. Fees range from 10 percent to 14 percent of a hospital's total charges for bad debt, indigent care, and charity care, depending on the amount of such care provided. Investor-owned hospitals receive credit against the license fee for property taxes paid. The estimated $60 million collected annually is to be redistributed for health care purposes, including payments to hospitals with high volumes of indigent care, charity care, and bad debt. The license fee is scheduled to sunset after two years.

RATE-SETTING "ADD-ON" MECHANISMS. Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York provide for uncompensated care costs through their hospital rate-setting programs by adding an allowance to each hospital's rates to help cover such costs. These add-on charges are a broad-based revenue source addressing

compensation for both charity care and bad debt. The mechanism also provides funding without appearing as an additional line item in a government budget.

One disadvantage of the all-payer systems is that they are tied to regulatory rate-setting structures which are not politically attractive in many states. In addition, it has become more difficult to obtain a federal waiver allowing states to include Medicare in their all-payer hospital rate-setting systems.

Gail Wilensky also notes that such all-payer systems pay for care at whatever hospitals individuals use, as opposed to directing them to the most efficient hospitals. New York and New Jersey have taken steps to address the inefficiency problem. New York collects its add-on revenues and distributes them to regional indigent care pools. Funds are allocated to hospitals according to several criteria, including how much uncompensated care they provide and whether they have an adequate collection procedure. New Jersey established its Uncompensated Care Trust Fund in 1987, which will collect about $500 million in 1989 through a uniform statewide hospital markup of about 10 percent of charges. Approximately one-third of the state's hospitals receive money from the fund.

TAX ON HEALTH INSURANCE PREMIUMS. Most insurance risk pools are subsidized by assessments on insurers. Iowa passed legislation in 1985 to assess a 2 percent tax on all Blue Cross/Blue Shield plans and other nonprofit health service corporation plans to help expand the state's medically needy program.

TAX ON EMPLOYERS. Massachusetts is the first state to enact legislation designed to guarantee health insurance to all of its uninsured residents. The Health Security Act of 1988 is designed to expand the number of businesses providing insurance to their employees. Other uninsured persons would receive insurance through a state program administered by the new Department of Medical Security. By 1992, businesses with more than five employees will be required to pay a surcharge of 12 percent of each full-time employee's first $14,000 in wages into a health insurance trust fund, up to a maximum of $1,680 per employee. Employers who provide health insurance can deduct those costs from the surcharge, resulting in major new costs only to employers who do not provide insurance. Although this approach is designed to comply with the federal ERISA provisions, it is unclear whether it would survive a court challenge.

The law also provides positive incentives for small businesses to provide insurance before the 1992 deadline. These include technical assistance to brokers for small business insurance, an insurance pool to provide group rates for businesses with five or fewer employees, and a new tax credit for total premium expenditures.

Revenues from the employer surcharge and premiums paid on a sliding scale by the uninsured would finance the health insurance trust fund, which is to cover all other uninsured persons. The law recommends that individuals pay an average 25 to 30 percent of the cost for the insurance policy. Coverage for the unemployed will be effective in 1990; coverage for uninsured employees will begin in 1992.

Oregon passed similar legislation in 1989, which will tax employers who do not offer insurance to their employees and dependents by January 1, 1994. As in Massachusetts, proceeds from the payroll tax will finance a state insurance fund to cover uninsured persons. Oregon's plan, called the Health Insurance Partnership Act, implements a tax credit for employers who offer insurance, which will be phased out by 1994. Unlike Massachusetts, very small businesses in Oregon will not be exempted from the requirements, although there will be an appeals process for "hardship" cases. New businesses moving into the state will be exempt from the requirements for up to 18 months, but will qualify for the tax credits. The Oregon initiative is a companion measure to the legislation described in Question Seven concerning the state's responsibility to provide health care to low-income persons. The Health Insurance Partnership Act is intended to define employers' responsibility for insuring workers and their dependents. A third bill, expected to pass in 1989, would provide funding for the state-sponsored insurance risk share pool for high-risk persons, which was created in 1987.

STATE INCOME TAX CHECK-OFF. Oklahoma sponsors a check-off on the state's income tax form for persons to donate a portion of their tax refunds to the Indigent Health Care Fund. Proceeds are distributed to qualifying outpatient clinics that serve indigent patients. During the first three years in operation, only about $150,000 was donated.

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